



**The New York  
Academy of Medicine**



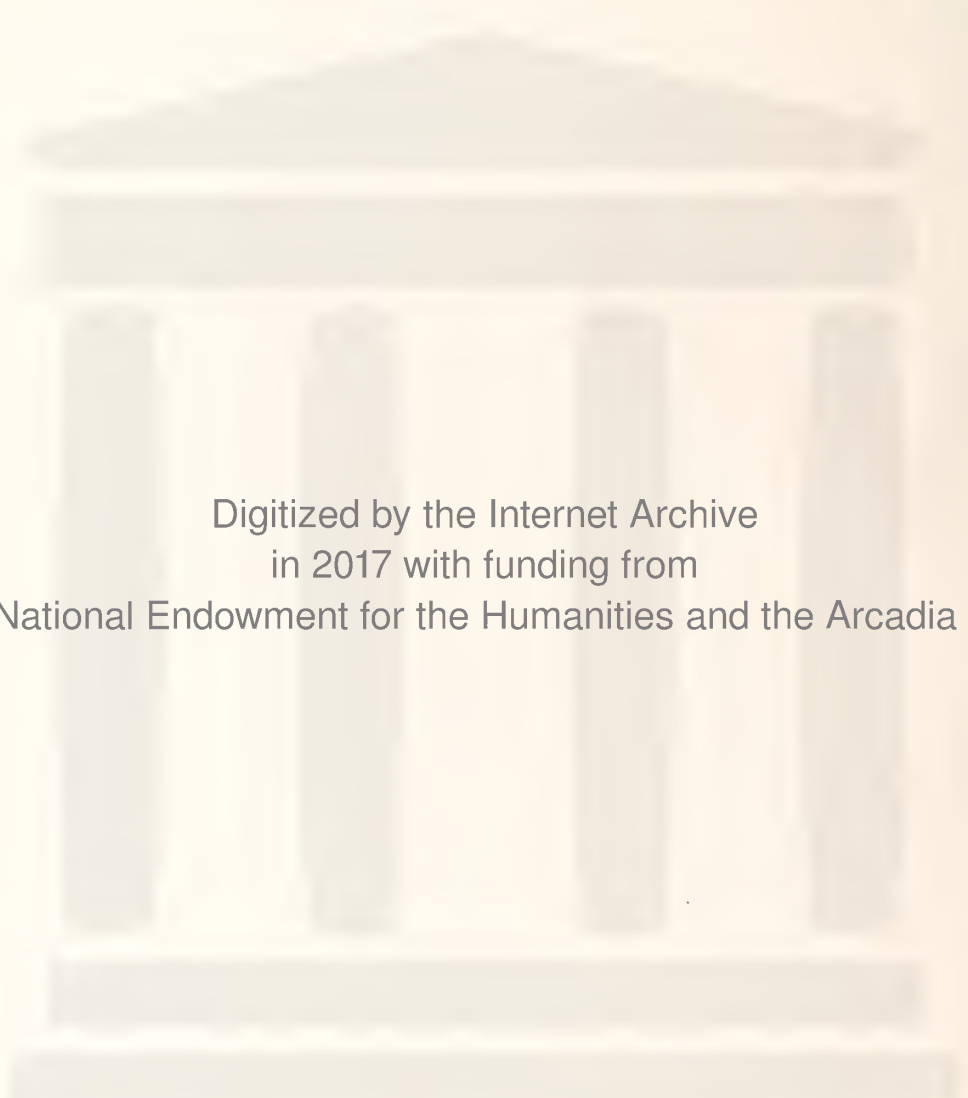
*Gift from the  
Publisher*











Digitized by the Internet Archive  
in 2017 with funding from  
The National Endowment for the Humanities and the Arcadia Fund

# HAWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

ME 10

SEPTEMBER-OCTOBER, 1950

NUMBER 1



## THE SURGEON'S RESPONSIBILITY IN THE CARE OF THE CANCER PATIENT

George T. Pack..... 19

## A STUDY OF THYROID DISEASE IN HAWAII

G. C. Freeman..... 27

## FOOD VALUES OF HAWAIIAN-GROWN FRUITS AND VEGETABLES

Carey D. Miller..... 34

FEATURES ..... 37

INTER-ISLAND NURSES' BULLETIN ..... 59

THE ACADEMY  
OF MEDICINE  
OCT 16 1950  
LIBRARY

10-11  
1950-52

*S*

... meaning "without". . . is a prescription symbol with which you are familiar. Less familiar to you, perhaps, is the fact that some of our "withouts" are highly important to physicians and their patients. For example, Eli Lilly and Company demands that the complete quantitative formula of active ingredients for every Lilly product be given to physicians—*without* any secrets, *without* extravagant therapeutic claims, *without* advertising or promotion to the laity.



ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

GRATIS X

these  
are  
the facts

LIBRARY

FEB -9 1954

LIBRARY

291601

PARKE, DAVIS & COMPANY



- 1. CHLOROMYCETIN®** is the first and only antibiotic to be prepared synthetically on a commercial scale.
- 2. CHLOROMYCETIN** is rapidly effective in a wide range of infectious diseases, including urinary tract infections, bacterial and atypical primary pneumonias, acute undulant fever, typhoid fever, other enteric fevers due to salmonellae, dysentery (shigella), Rocky Mountain spotted fever, typhus fever, scrub typhus, granuloma inguinale, lymphogranuloma venereum.
- 3. CHLOROMYCETIN is well tolerated**  
The progress of the patient is, therefore, unhindered by serious side reactions.
- 4. CHLOROMYCETIN** is administered by mouth or by rectum.  
Since the need for injection therapy is eliminated, treatment is simple and convenient.
- 5. CHLOROMYCETIN** controls many diseases unaffected by other antibiotics or the sulfonamides.
- 6. CHLOROMYCETIN's** remarkable antibiotic activity results in quick recovery, smooth convalescence, and rapid return of the patient to his customary activities. The end result is greater economy.

*packaging* Chloromycetin,  
(chloramphenicol, Parke-Davis),  
is supplied in Kapseals® 250 mg.,  
and in capsules of 50 mg.





NOW PROOF... in an instant, Doctor,  
PHILIP MORRIS are LESS IRRITATING

*Just Make This Simple Test:*



**1** ... light up a  
**PHILIP MORRIS**  
Take a puff—DON'T INHALE. Just  
s-l-o-w-l-y let the smoke come through  
your nose. Easy, isn't it? AND NOW...

**2** ... light up your present brand  
**DON'T INHALE.** Just take a puff and  
s-l-o-w-l-y let the smoke come through  
your nose. Notice that bite, that sting?  
Quite a difference from PHILIP MORRIS!

**YES**, your own *personal experience* confirms the results of the clinical  
and laboratory tests.\* With proof so conclusive, would it not be good practice to  
suggest PHILIP MORRIS to your patients who smoke?

**PHILIP MORRIS**

Philip Morris & Co., Ltd., Inc.  
100 Park Avenue, New York 17, N. Y.

\**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;  
*Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60





**release  
the**

# FLOOD GATES

## *in Cardiac Edema Control*

"... the diuretic drugs not only promote fluid loss but in many instances also effectively relieve dyspnea ... not only may the load on the heart be decreased but there may also occur an increase in the organ's ability to carry its load ... With good average response the patient perhaps voids about 2000 cc. of urine daily, but in exceptional instances the amount rises to as high as 8000 cc."<sup>1</sup>

"Not only are the diuretics of immense value in cases of left ventricular failure ... but where edema is marked, as it is most likely to be in failures occurring in individuals with chronic nonvalvular disease with or without hypertension and arrhythmia, their employment is often productive of an excellent response. In [edematous patients with] active rheumatic carditis (rheumatic fever) the use of these drugs may be life-saving."<sup>2</sup>

Salyrgan-Theophylline is effective by muscle, vein or mouth.

# **salyrgan<sup>®</sup>** **THEOPHYLLINE**

**BRAND OF MERSALYL AND THEOPHYLLINE  
TIME TESTED • WELL TOLERATED**

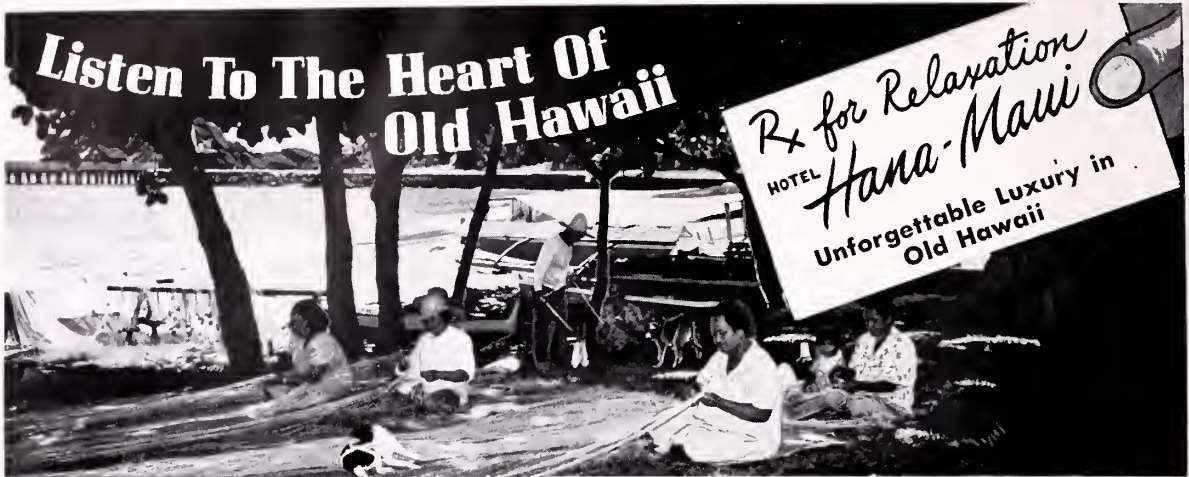
*Winthrop-Stearns* INC.  
NEW YORK, N. Y. WINDSOR, ONT.

AMPULS (1cc. and 2cc.) • AMPINS (1cc.) • TABLETS

1. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 5th ed., 1946, 704-705.

2. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 6th ed., 1948, 744.

Salyrgan, trademark reg. U. S. & Canada—Ampins, reg. trademark of Strang Cabb & Co., Inc.



At Hana, Maui, you'll be in another world, where centuries stand still. There you'll come upon the luxury of beautiful Hotel Hana-Maui, hidden deep in the legend-haunted grounds of Hana. There where old Hawaii lives on, you'll find superb food, accommodations and recreational facilities—all the things you like to do . . . and all the time in the world to do nothing!

Bask in the balmy breezes that rustle jungle

foliage over tranquil Hana Harbor. Leave your cares and worries behind . . . and head for Hana, Maui!

Honolulu Reservations Office:  
Outrigger Arcade — Phone 90-0355

HOTEL *Hana-Maui*

JUST AN HOUR BY AIR  
FROM HONOLULU

## Planning a Trip? Then take a tip from your Travel Specialists!

International Travel Service has a six point centralized travel service that can be a great help to you . . . and there is no extra charge! HERE IS WHAT WE HAVE TO OFFER . . . . .

1. We have complete information about air, sea, bus and rail facilities anywhere in the world.
2. We obtain reservations and issue tickets.
3. We arrange personal and baggage insurance.
4. We can arrange complete tours including hotel reservations and all details.

5. We offer professional travel advice that will save you time, money and innumerable annoyances.
6. We will call at your home or office at your convenience to deliver tickets and make all other arrangements.

*P.S. You don't have to travel to Timbuctoo to take full advantage of our services. We can arrange wonderful tours right here in the Islands and handle reservations for flights to the other Islands. . . !*



# INTERNATIONAL *Travel Service*

In Honolulu: 44 South King at Bethel—phone 6-7558  
In Waikiki: Outrigger Arcade—phone 9-3355  
On Hawaii: 50 Woienvenue Ave., Hilo—phone 4-2313  
On Maui: Maui Realty Bldg.—phone 6915



MR. LOUI



MR. MacGREGOR



	Calories	Protein Gm.	Calcium Gm.	Copper mg.	Iron mg.	Phosphorus Gm.	Vitamin A I. U.	Thiamine mg.	Riboflavin mg.	Niacin mg.	Ascorbic Acid mg.	Vitamin D I. U.
National Research Council Allowances, Sedentary Man (154 lbs.)	2,400	70	1.0	1.2	12	1.5	5,000	1.2	1.8	12	75	Small Amount
Ovaltine in Milk, 3 Servings*	676	32	1.12	0.5	12	0.94	3,000	1.16	2.0	6.8	32	417
Percentages of N. R. C. Allowances Provided by 3 Servings* of Ovaltine in Milk	28%	46%	112%	42%	100%	63%	60%	97%	111%	57%	40%	Abun- dance

\* Each serving made of 1/2 oz. of Ovaltine and 8 fl. oz. of whole milk.

# Supplementation

**A sure step to dietary adequacy**

The aim of the dietary at all times and under all conditions is to provide ample amounts—not just minimum amounts—of all nutrient essentials. Only when the daily nutrient intake is fully adequate, based on the most authoritative nutritional criteria, can the possibility of adequate nutrition be assured. It is for this reason that a food supplement assumes great importance in daily practice. It should be rich in those nutrients most likely deficient in prevailing diets or in restricted diets during illness and convalescence.

The multiple nutrient dietary food supplement, Ovaltine in milk, is especially suited for transforming even poor diets to full nutritional adequacy. This is clearly shown by the data in the table above.

Note in particular the high percentages of the dietary allowances for nutrients and the relatively low percentage of the total calories furnished by the servings of Ovaltine in milk. Thus, without unduly increasing the caloric intake, Ovaltine in milk greatly increases the contribution of nutrient essentials. Enticing flavor and easy digestibility are other important features of this dietary supplement.

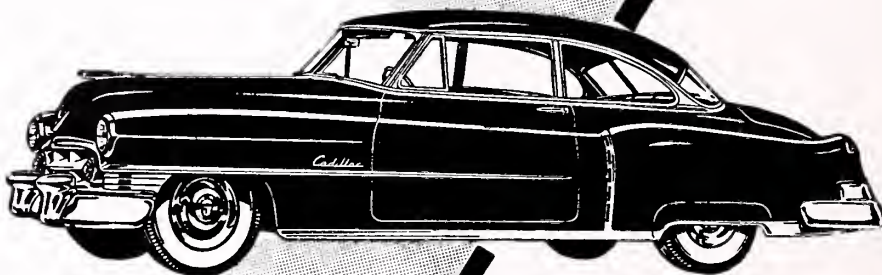


Two kinds, Plain and Sweet Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

## Ovaltine

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

# Always on CALL



YOUR NEW

*Cadillac*

As dutiful as it is beautiful.  
Providing years and years of durable,  
dependable service plus luxurious motoring  
comfort.

CADILLAC—first choice of discriminating Islanders.



**SCHUMAN CARRIAGE  
COMPANY**

Established 1893

BERETANIA AT RICHARDS STREET,

HONOLULU

## PERITONITIS: what's the risk?

*Careful enteric surgical technics have lowered the risk of peritonitis greatly; preoperative administration of SULFASUXIDINE reduces it even further, and postoperative use of this highly efficient bacteriostat speeds and simplifies convalescence.*



**Description:** Relatively nontoxic; only 5% absorbed into blood; rapidly excreted by kidneys. Maintains high bacteriostatic concentration in bowel.

**Indications:** (1) Before enteric surgery, to minimize risk of peritonitis; afterward, to speed and simplify recovery. (2) Ulcerative colitis. (3) Bacillary dysentery, acute or chronic, including carrier state. (4) Combats urinary tract infection due to *E. coli*, by lowering enteric bacterial reservoir.

**Dosage:** Initial, 0.25 Gm./kilogram; maintenance, 0.25 Gm. kilogram/day, 6 doses, 4-hour intervals. Supplied in 0.5-Gm. tablets, bottles of 100, 500, 1,000, and (oral) powder, 1/4 and 1-lb. bottles. Sharp & Dohme, Philadelphia 1, Pa.

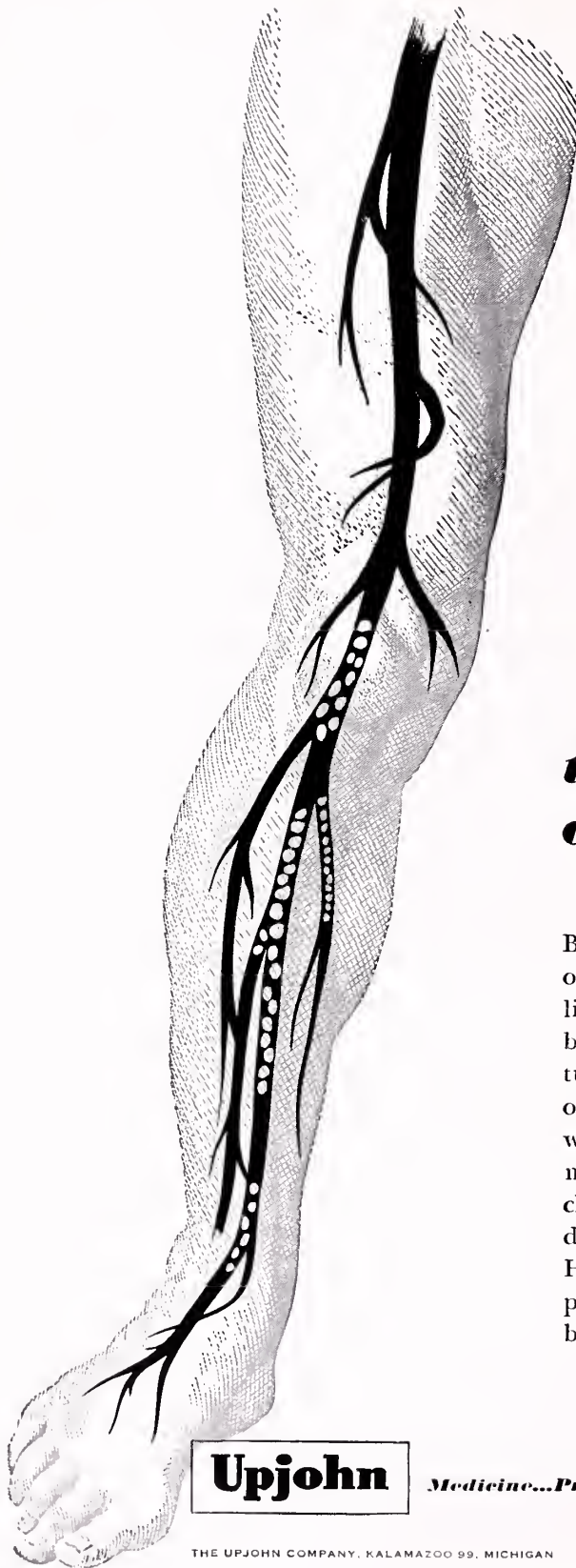


# Sulfasuxidine®

*succinylsulfathiazole*

THEODORE H. DAVIES CO., HONOLULU • SOLE DISTRIBUTORS





## ***the probability of thrombi...***

Both morbidity and mortality from post-operative venous thrombosis and embolism, frequent sequelae to surgery, have been dramatically reduced by early institution of anticoagulant therapy. Studies of anticoagulants by Upjohn research workers have led to the development of many Heparin Sodium preparations, including long-acting Depo\*-Heparin Sodium, with or without vasoconstrictors. Heparin Sodium preparations provide promptly effective and readily controllable anticoagulant therapy.

\*Trademark, Reg. U. S. Pat. Off.

**Upjohn**

*Medicine...Produced with care...Designed for health*

THE UPJOHN COMPANY, KALAMAZOO 99, MICHIGAN



**AMPHOJEL'S ANTACID GEL**

raises gastric pH to  
noncorrosive levels



**AMPHOJEL'S  
DEMULCENT GEL**  
coats gastric  
mucosa with  
protective film

**double  
protection**



**For the Peptic Ulcer Patient**

"Double gel" action

**AMPHOJEL<sup>®</sup>**

ALUMINUM HYDROXIDE GEL WYETH

Provides prompt relief... no alkalosis  
or acid rebound. For sustained  
benefit, prescribe AMPHOJEL LIQUID  
for home and office therapy,  
supplemented with AMPHOJEL TABLETS  
for handy "between times" therapy.

LIQUID: Bottles of 12 fl. oz. TABLETS: 10 gr.,  
boxes of 60; 5 gr., boxes of 30, bottles of 100

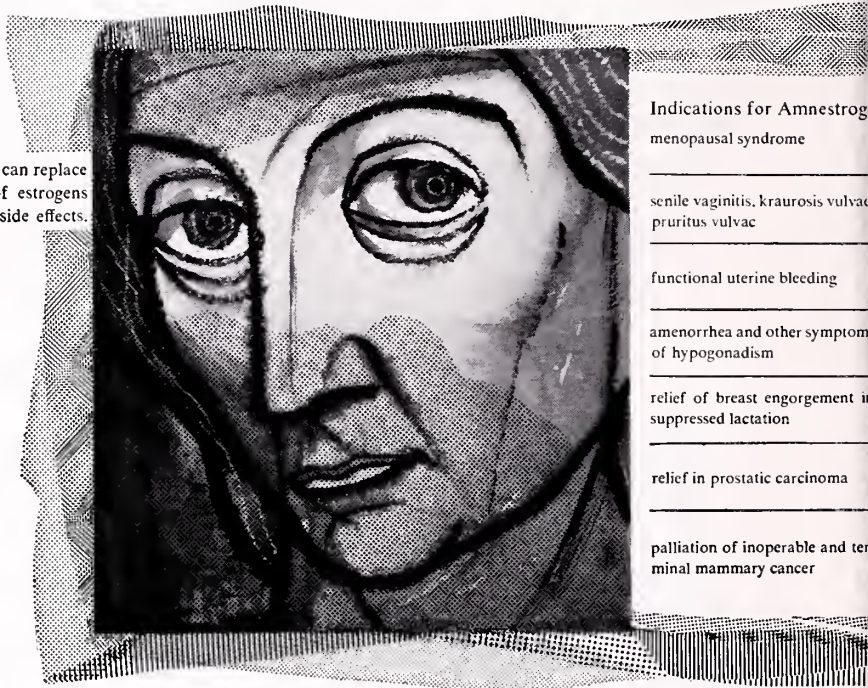
*Wyeth* Incorporated • Philadelphia 3, Pa.



*Whenever estrogens are indicated...*

## **Amnestrogen**

With Amnestrogen you can replace  
physiologic amounts of estrogens  
...with minimal side effects.



Indications for Amnestrogen  
menopausal syndrome

senile vaginitis, kraurosis vulvae  
pruritus vulvae

functional uterine bleeding

amenorrhea and other symptoms  
of hypogonadism

relief of breast engorgement in  
suppressed lactation

relief in prostatic carcinoma

palliation of inoperable and terminal  
mammary cancer

*whenever estrogens are indicated... Amnestrogen*



## *a complete, smooth estrogenic effect*

The potency of Amnestrogen is expressed as sodium estrone sulfate—a true steroid hormone. It is smooth-acting and naturally occurring; water-soluble, and rapidly absorbed.

**DOSE**—One 1.25 mg. tablet daily or 0.625 mg. twice daily or 0.3 mg. four times daily. for 1 or 2 weeks and thereafter the smallest dose which will prevent return of symptoms.

**DOSES**—2.5 mg. daily, or 1.25 mg. twice daily.

—1.25 mg. or more daily.

for 3 to 5 days or until bleeding stops. non-endocrine causes to be first excluded. therapy with progesterone should be considered.

individualized according to development of secondary sex characteristics. In amenorrhea 75 mg. daily for 24 days, accompanied by progesterone therapy.

for 2 or more days.

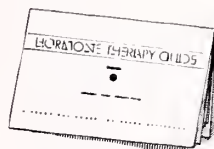
on 3.75 mg. daily for several weeks; then halve the dosage.

;\* for at least 2 months for subjective response and 5 months for objective response. should not be given to a woman with breast cancer who is less than 5 years postmenopausal. whose disease is amenable to surgery or roentgen ray. \*New and Non-official Remedies, 1950, (in press).

IS A TRADE MARK OF E. R. SQUIBB & SONS

*Literature  
available  
upon  
request*

*E. R. Squibb & Sons,  
745 Fifth Avenue,  
New York 22, N. Y.*

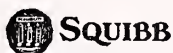


**potencies for flexibility in dosage:** 0.3 mg.—100's; 0.625 mg.—100's, 1000's;

1.25 mg.—100's, 1000's; 2.5 mg.—25's, 100's.

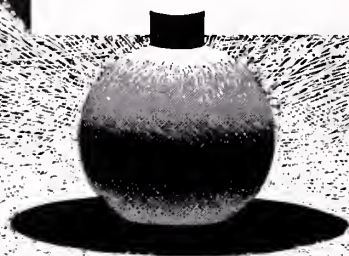
# Amnestrogen

Squibb Conjugated Estrogens; Potency Expressed as Sodium Estrone Sulfate



**SQUIBB**

THE REAL DANGER IN  
POTASSIUM  
DEFICIENCY  
IS LACK OF  
EARLY RECOGNITION

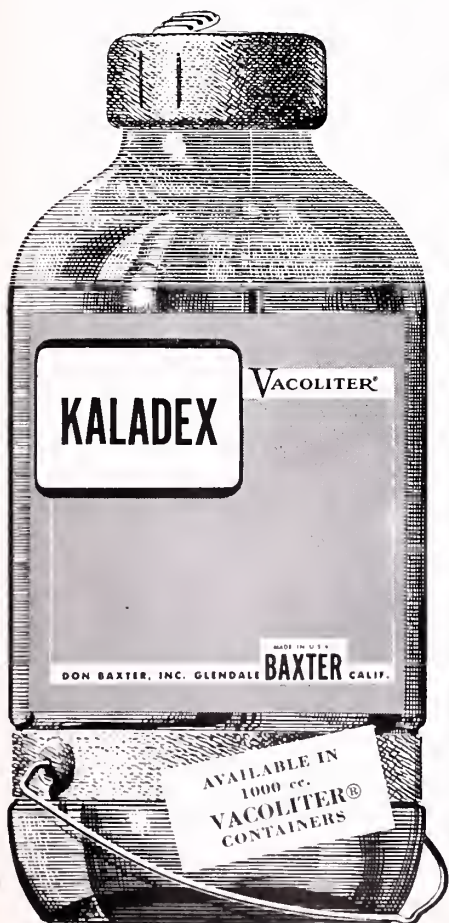


Know the causes . . . look for the symptoms and signs . . .  
treat promptly with

KALADEX

(Baxter 0.2% Potassium Chloride in 5% Dextrose Solution)

*Write for free abstract of the literature on  
potassium deficiency*



DON BAXTER, INC. • RESEARCH AND PRODUCTION LABORATORIES  
GLENDALE 1, CALIFORNIA

*Territorial Distributor: CROCKETT SALES COMPANY P. O. Box 3017 Honolulu, T. H. Phone 6-8992*



# HAWAII MEDICAL JOURNAL

## and INTER-ISLAND NURSES' BULLETIN

Volume 10  
Number 1

SEPTEMBER-OCTOBER, 1950

\$2.00 per Year  
35c per Copy

Published Bi-Monthly by

THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

### THE HAWAII TERRITORIAL MEDICAL ASSOCIATION 1950-1951 OFFICERS

R. L. HILL, Honolulu.....	President
H. L. ARNOLD, JR., Honolulu.....	President-Elect
LEO BERNSTEIN, Hilo.....	Vice-President from Hawaii County
S. L. YEE, Honolulu.....	Vice-President from Honolulu County
WILLIAM GOODHUE, Eleele.....	Vice-President from Kauai County
R. F. COLE, Paia.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

#### COMMITTEE CHAIRMEN

GROVER A. BATTEN.....	{ Cancer Committee
SAMUEL D. ALLISON.....	{ Resolutions Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	Health Education Committee
WILLIAM H. STEVENS.....	HAWAII MEDICAL JOURNAL
SAMUEL L. YEE.....	Committee on Psychiatry and Neurology
THOMAS H. RICHERT.....	By-Laws Committee
RICHARD C. DURANT.....	Advisory Board for Woman's Auxiliary
HARRY L. ARNOLD, JR.....	Public Service Committee
LAURENCE M. WIIG.....	Committee on Public Policy and Legislation
VERNE C. WAITE.....	Scientific Works Committee
ROBERT D. MILLARD.....	Postgraduate Committee
	Fee Schedule Committee

#### OFFICERS—COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....L. Bernstein, Hilo	S. L. Yee	W. Goodhue, Eleele	R. F. Cole, Paia
<i>Vice-President</i> .....T. D. Woo, Pepeekeo	J. W. Devereux	K. K. Fujii, Kapaa	E. Kushi, Wailuku
<i>Secretary</i> .....P. Okumoto, Hilo	W. Walsh	K. Kuhlman, Koloa	E. T. Shimokawa, Lahaina
<i>Treasurer</i> .....M. L. Chang, Hilo	W. Ito	K. Kuhlman, Koloa	E. T. Shimokawa, Lahaina

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1950, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second-class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.



... with a Solid Foundation

For the infant, a sound future depends largely on the kind of nourishment given in the first few all-important months of life.

These are the months when the demand for protein is greatest. And that's one good reason why DRYCO is often recommended when necessary to supplement or replace breast feeding.

It is the 2.7 to 1 ratio of protein to fat in DRYCO formulas that gives this trusted milk such an outstanding advantage, for

it most nearly approximates the balanced *nourishment* and *digestibility* of milk from the human breast.

#### Solid Nourishment—Vitamin Fortified

Always the best fresh milk, modified to provide a ratio of 2.7 to 1 of protein to fat, easily digested, moderate carbohydrate content permitting flexibility, vitamin enriched—and specially packed to retain its original freshness in any climate—that's DRYCO!

Write for detailed information to:

**THE BORDEN COMPANY, Export Division**  
350 Madison Avenue, New York 17, N. Y., U. S. A.

**DRYCO**  
VITAMIN FORTIFIED



# The Surgeon's Responsibility in the Care of the Cancer Patient

GEORGE T. PACK, M.D.

NEW YORK

THE purpose of my remarks today is to define the basic philosophy by which I am guided in the management of patients with cancer. I believe that one cannot do justice to the cancer patient without an understanding of this fundamental attitude of mind toward these unfortunate patients.

## The Pronouncement of Cancer

One of the most unfortunate and delicate duties to confront a physician is the pronouncement of the existence of a cancer. The unfortunate odium that has long attended this disease, and the false legends of its incurability, have conspired to make the occasional patient accept this diagnosis as a verdict worse than death. The ability to receive such unwelcome news with fortitude and equanimity is an attribute denied the majority of individuals. Inasmuch as the qualities of courage, intelligence and emotional stability are so variable in humans and because it is the physician's task to treat the mind and spirit as well as the body, no set rule can be formulated for acquainting all cancer patients with the diagnosis and prognosis of their ailment.

This discussion would be unnecessary if it were the universal practice of doctors to use an immediate, direct, and blunt declaration of this diagnosis and to permit the patient and his family to react and adjust themselves as well as possible to this seeming catastrophe. The protagonists of this method of handling the problem might well quote one of the aphorisms of Johann Kasper Lavater, who said: "He who, when called upon to speak a disagreeable truth, tells it boldly and has done is both bolder and milder than he who nibbles in a low voice and never ceases nibbling." It is surprising how much vicarious strength of character some physicians possess for suffering their patients' diseases. We cannot limit the occurrence of cancer to the brave and the strong. Further-

more, a patient endowed with the most heroic stoicism at the time of receiving the pronouncement of cancer, may after a few months of insomnia, constant pain, and progressive disability, become almost another individual, desperate and craven, who has lost his courage, but unfortunately not his memory.

The family physician who knows the personality, the character, and the familial environment of the patient, seldom undertakes the management of the cancer; therefore, it usually falls to the lot of the unacquainted radiation therapist or surgeon to establish the diagnosis, to propose the plan of treatment and to satisfy the inquisition of the patient and his relatives at the initial consultation. Under these circumstances, he faces at once the difficult task of making a rapid and accurate evaluation of the psychological status of the patient and governs his immediate actions accordingly. Although the suspicion of cancer may be present in the mind of each patient, only a few will have the temerity to ask the direct question, "Doctor, do I have cancer?" By this time, the physician probably has decided whether to be explicit about the diagnosis, and if so at what time, and in what manner, the patient should be told. There are moral, professional and legal reasons for replying truthfully to the direct interrogation. For example, a responsible, sane individual, with great family, economic or social liabilities which are dependent on his well-being, may need to rearrange his plans because of such a diagnosis and the future program it entails. The truth at such a time may be cold and cruel or gentle and merciful, according to the manner of the informer. To allay the apprehension of the patient, to bolster his morale, and to give him an optimistic viewpoint



DR. PACK

Chief of the gastro-enterology surgical service at the Memorial Hospital, New York City.

Transcript of an address delivered before the 59th annual meeting of the Hawaii Territorial Medical Association, May 6, 1949. Received for publication May 2, 1950.



about his condition for the weeks of treatment ahead, considerable stress should be laid on the various encouraging aspects pertaining to his particular cancer.

The physician may be forewarned by the general practitioner or through the intervention of the family not to inform the patient about the true character of his illness. In this case, one should distinguish as Shakespeare did between the lie direct and the lie with circumstance. The reasons for acceding to this request must be important and purposeful, not based on mere sentiment. As Mr. Dooley said, "I think a lie with a purpose is wahn iv th' worst kind an' the mos' profitable." If one is constrained to tell such a white lie to a patient, hysterical, profoundly melancholic, or otherwise mentally unstable, it should be done in the presence of witnesses, preferably the general practitioner in the case or another medical consultant, who agrees as to the necessity for such a procedure. This precaution, especially the signatures of such witnesses, affords protection against possible future legal complications. With such evidence available, the courts of justice would not condemn the altruistic intent of the physician. If the same patient refuses to undergo the radical treatment prescribed under the false assumption that it is unnecessary, or if he procrastinates too long before starting therapy, or if he moves immediately from the community and is no longer under the control of the responsible physician, then secrecy is abandoned and the patient is correctly apprised of the serious character of his disease.

One technique not to employ is the gracious smile, the friendly pat on the shoulder, the nonchalant assurance of the minor unimportance of the disease and in the same breath the proposal to do a hip joint disarticulation, a radical mastectomy, an abdominoperineal rectal resection with permanent colostomy or a protracted course of intensive radiation therapy. Such paradoxical behavior leads inevitably to loss of confidence and respect and convicts the physician either of lying or of exercising bad judgment. It is a wise physician who anticipates and forestalls complicating questions from the patient. The average patient expects the worst and, in the light of the treatment planned for him, is naturally and reasonably dissatisfied or hesitant with any ambiguous explanation or one that doesn't admit the serious character of his disease. This doubt can be dispelled by asserting in the beginning that the patient does have a "tumor" endowed with dangerous potentialities. Proceed to explain that, without early and appropriate treatment, this tumor is capable of changing its localized status and may become

generalized. Encourage the patient by the fact that the "tumor" is amenable to therapy and rightly defend the major form of treatment advocated as the procedure most likely to offer the patient the safety he wishes and deserves. The word "cancer" is intentionally omitted from the conversation. The average patient realizes that the disease is really cancerous or perhaps precancerous and agrees to treatment, at the same time gratefully appreciating the consideration of the physician in not openly labelling the tumor as "malignant." By avoiding the use of the word "cancer," the doctor may allow the patient always to cherish the hope that the tumor has not become cancerous as yet; the patient would rather retain this thread of healthy doubt and uncertainty, than to have once and forever the finality that goes with the pronouncement of cancer. As times goes by the patient becomes fully cognizant of the nature of the disease he has and a tacit understanding develops between him and the physician during the observational years that follow.

Queries concerning prognosis follow the diagnosis as the night the day. A frank discussion of the outlook in any individual case is fraught with certain hazards. A recital of percentage figures for operative mortality and five year survivals, regardless of how good they seem to the professional mind, are not particularly reassuring to the patient: they always fall short of perfection. "After all," he reasons, "I may be one of the fatalities or failures." No cancer is so slight as to be considered insignificant and many cancers apparently hopelessly advanced are sometimes controlled; therefore, the physician, since he cannot always guide the many intangible influences that may render the early cancer incurable and the advanced cancer controllable, should be most cautious in guaranteeing a cure or dwelling on the futility of treatment, respectively. The patient's family will never forgive a guarantee of cure that failed, and the patient will not let the physician forget a pronouncement of incurability if he is so fortunate as to survive.

### The Palliative Treatment of Cancer

The existent attitude of the laity and of many physicians toward the control and cure of cancer apparently is an unaltered relic of medieval superstition. The conception of cancer as an incurable disease is widely accepted by many people, including not a few physicians, in spite of the laudable educational efforts of the American Society for the Control of Cancer and other organizations toward dispelling this belief. It is true that some individual cancers are incurable and the

hopelessness in the given case may be recognized and pronounced by the physician at the initial examination, yet the published figures of thousands of cancer cures should exert an influence in changing this point of view toward cancer as a whole, even with the most dismal pessimist.

The diagnosis of arteriosclerosis, chronic nephritis, diabetes mellitus, myocarditis, coronary vascular disease, osteitis deformans, and many other degenerative conditions is accepted with equanimity, fortitude, and optimism by the majority of patients, and yet in the category of end-results of treatment they are all *incurable* diseases. Even in cases of tuberculosis or of pernicious anemia, one refers to an arrest rather than to a cure. When confronted with one of these incurable conditions in his own person, the patient asks of his physician only that treatment which lies within the realm of possibility, hoping that it will successfully arrest the process for the time being, avoid the complications and disabilities attendant on the disease, and prolong his life in comfort. Not so is the attitude of the same patient and his family if the diagnosis be cancer: in this event, nothing short of a guarantee of cure seems to suffice. An expression by the physician of a reasonable doubt concerning an ultimate cure or a statement covering the statistical chances (if less than 100 percent) frequently leads to a profound and unreasonable reaction in which a decision is made to refuse all treatment, surgical or radiologic. In other words, palliative treatment is eagerly accepted for all incurable diseases except cancer; its employment for cancer is generally regarded with skepticism and without enthusiasm. In the eyes of the family, the patient is practically dead the moment a pronouncement of incurability is made.

The medical profession has not been faultless in this regard. The accent has constantly been on cure rather than palliation; naturally this is a commendable effort. Published figures on the end-results of treatment from institutions, surgeons and radiologists specializing in cancer therapy, usually present as the culmination or reward for their efforts, the percentages of so-called five-year cures, or survivals without recurrence for five years. Such figures may vary from 10 to 90 percent of the cancers treated, depending on the regions involved, stage of the disease, histological types, etc. The reader accepts this figure as the sole expression of life salvage in the group of patients studied. If an economist were to analyze the same data, he would undoubtedly devote some attention to the great group of cases which are usually summarily dismissed from consideration as failures of cure. This analysis would bring to

light and properly accredit the palliative benefits derived in the short-term (less than five-year) survivors.

If radiological and surgical treatments do prolong the lives of incurable cancer patients, there should be some means of expressing the advantage in a statistical manner, and such results should be duly published. Only in such a way can comparable results of palliative treatment be properly evaluated and improved. One method is to determine, for each regional variety of cancer, the average length of life without treatment, from the time of onset of symptoms to death. The percentages of patients living without treatment for one, two, three, four, and five years can be plotted in a curve, which constitutes a "natural yardstick" against which the cancer therapist can plot the results of palliative treatment of breast cancer. Similar yardsticks for measurement of the average duration of life without treatment should be plotted for cancers of all regions and organs. The general acceptance of such tables would afford all hospitals and physicians treating cancer an opportunity to determine the palliative value of any treatment they are wont to use.

The prolongation of life itself is, of course, not the only measure of palliation. No one wishes to live longer in order to suffer more. The indications for palliative efforts are the relief of pain and discomfort, the healing of ulcerated lesions, the lessening of hemorrhage and infection, the repair of certain pathological fractures, the healing of metastases in bone, the eradication of cough and dyspnea, the restitution of sleep, the delay in generalization of the cancer, and many other well known and admitted benefits of treatment chiefly by radiation methods. It is possible that well judged and appropriate irradiation, for example, might accomplish one or all of the above enumerated benefits without prolonging the life of the individual; yet none would deny that such efforts are worthwhile.

Surgical measures which have been employed for palliative purposes are resection of offensive cancers which are infected, foul, bleeding, or obstructing, the abolition of pain by the severance of sensory nerve tracts or by the injection of alcohol into proper nerves, and the relief of obstruction by short-circuiting operations, chiefly on the gastro-intestinal and urological systems. Radiologists have an even greater scope for their palliative efforts in the use of x-rays and radium, the only known agents to effect the cure and palliative relief of cancer with the preservation of the surrounding normal tissues. Surgery may divorce the patient from his cancer, but does so by amputating



a member or removing a part or a whole of the organ involved, providing the organ is not essential to life and the cancer has not disseminated. Strictly speaking, the ideal cure is the destruction of the cancer with preservation of the host tissues, and radiation therapy is the nearest, in fact the only method devised to date which approaches this principle.

### The Definition of Inoperability of Cancer

The greatest margin for error in reporting the end-results of treatment for cancer may be found in the classification by the reporter of a regional or histologic type of cancer as operable or inoperable. The difficulty in correcting this fault is apparent when one realizes that three variable factors interplay in the pronouncement of a given cancer as non-resectable by any surgeon, namely: first, the condition of the patient as regards his age, the co-existence of degenerative diseases and the complications attendant on the presence of the cancer; second, the extent of the disease, meaning the degree of local or organic involvement, the specific organ or tissue implicated, the extension to and incorporation of neighboring viscera by the cancer and metastases to regional and distant sites; and third, the surgical philosophy, moral point of view, courage, and experience of the surgeon. In a large group of patients with generalized bone metastases, or diffuse involvement of lungs or liver, or peritoneal carcinosis or melanomatosis, the recognition and acceptance of inoperability is obvious to any physician. But there are too numerous other instances in which the definition of inoperability may be subjected to careful evaluation, criticism, and even condemnation.

### The Point of View of the Surgeon

It is not my purpose to formulate a set of rules governing the behavior of the surgeon in a given instance, but rather to present certain arguments for extending the scope of operability for cancer. The very nature of this disease, the infirmities and often advanced age of the patients in whom it so frequently develops, and the radical character of the numerous operations designed to combat it, all conspire to make the surgical treatment of cancer a hazardous venture for the patient and often an ordeal for the surgeon. With the knowledge of the inevitability of death from cancer that is not treated, it seems unnecessary to state that no surgeon would refuse a patient the slightest chance for cure or even relief because of a fear of criticism for failure or a misguided pride in low figures of operative mortality. Nor should any

surgeon attempt to play God and decide arbitrarily that a certain cancer patient has lived a sufficiently long life or that he has so few remaining years of even normal life expectancy that operation at best would hardly be worth while. We must take care, in our weighty decisions concerning the denial or offering of a chance for life to a patient, that in our desire not to be executioner, we do not achieve the same end-result by acting as an immoral judge. For example, if called upon to operate for a ruptured duodenal ulcer on a condemned criminal awaiting electrocution in the death row, the surgeon by his calling and in keeping with the Hippocratic Oath, operates with the same skill and renders just as meticulous post-operative care as if his patient were to live forever.

### Inoperability and Incurability

Many operations designed for the cure of cancer achieve too often only a palliative end-result. If inoperability were an absolute state, and not a relative one, dependent in some cases on the criteria of the surgeon, the term would be synonymous with incurability. The unpredictable behavior of cancers, and the immeasurable host-resistance of organs and tissues to the growth of cancer, combine to create many intangible factors that make the early cancer occasionally incurable and the advanced cancer sometimes controllable. Assuming that a given cancer is not suitable for radiation therapy, operative removal becomes the only recourse. At the time of laparotomy, for example, a surgeon may be compelled to render judgment absolutely governing the life of the individual, the decision necessitating a matter of a few minutes as compared to days and weeks of courtroom deliberation by judge and jury. The closure of an abdominal wound on a cancer that is obviously hopeless is always done reluctantly, but the abandonment of an operation that is of questionable accomplishment must plague the conscientious surgeon for many sleepless hours and is one of the many reasons why he remains forever humble. He must worry whether his definition of inoperability is in his state of mind or moral courage or in the actual stage of the cancer. An aggressive attack on cancers presenting almost insuperable technical difficulties will sometimes result in palliative relief and occasionally in cures, but with mounting operative fatalities. Under these conditions, no one would impugn the good intent of the operator.

### The Age of the Cancer Patient

One cannot become reconciled to the perverted point of view of some surgeons who are unwilling



to operate on aged patients for major forms of cancer. Minor cancers that run a chronic course may not endanger the life of the patient, but a major cancer should be removed regardless of the age of the patient, providing it is technically possible and his physical state is not too precarious. The anatomic and physiologic age of the subject are infinitely more important than the chronologic age. At times, it would seem wiser to leave the actual age off the chart or for the patient conveniently to forget the number of years he has lived, if the knowledge of age alone unfavorably influences the surgeon; the fitness for the surgical ordeal would then be rightly determined by the true condition of the patient as judged by physical examination and laboratory tests. The proverbial three score years and ten, however collectively applied, do not concern us when we reach that age, because most of us, including patients, live from day to day and year to year, as if we were immortal. Some aged patients continue to possess a zest for life, and they merit every opportunity for cure or relief from otherwise fatal diseases that accidentally befall them; this is their privilege and their right regardless of advanced years, just as their rights of franchise, speech and worship continue. Rather than refuse to operate, the surgeon may justifiably modify or simplify the character of the operation; for example, he may do a simple mastectomy under local anesthesia for cancers of the breast that have apparently not metastasized to the axilla.

### The Condition of the Patient

For every argument advanced against the decision to operate on any given patient, the irrefutable defense or rebuttal is the inevitable fatality from the untreated cancer. What would the surgeon do if confronted with an acute surgical emergency in the same patient, e.g., a ruptured duodenal ulcer or gangrenous extremity? A patient with cancer, who is gravely ill from the conjoined effects of the cancer and intercurrent diseases, of course would receive medical consultation, careful deliberation concerning the choice of anesthesia, meticulous preoperative preparation. The family should jointly assume with the surgeon the responsibility of undertaking to remove a major cancer in a patient who is a serious operative risk.

One illustrative case is that of an elderly woman, bedridden and almost helpless for years due to amyotrophic sclerosis, on whom a radical mastectomy was done. This chronic invalid was a most cheerful individual and the nucleus of a happy home with husband and children even more

affectionate and concerned about her recovery and cure than is ordinarily the case. A 70-year-old woman, seriously handicapped by heart disease, underwent an almost total gastrectomy for a huge leiomyosarcoma of the stomach. The jejunum was anastomosed to only a rim of the stomach below the cardia. After a stormy convalescence, she recovered and now, 12 years later and 82 years old, is living and well except for the necessity of supportive treatment for her heart. An elderly woman entered the Memorial Hospital with a leiomyosarcoma of the uterus so large that it filled the entire abdomen and extended up as far as the epigastrium. She was in severe heart failure, did not respond to medical treatment, and was classified as inoperable by cardiologists, who warned us not to attempt any surgical procedure. On the other hand, she was experiencing hemorrhages of increasing severity. Because she could not lie recumbent, the operation was done in a modified Fowler's position; and under local anesthesia, an incision was made from the pubis almost to the ensiform cartilage and a panhysterectomy was done, including a liberal vaginal cuff. She was discharged from the hospital two weeks later with greatly improved cardiac compensation due, we thought, to the removal of this massive tumor.

### The Stage and Extent of the Cancer

The inoperability of an abdominal cancer is unquestioned in the presence of extensive hepatic metastases or peritoneal carcinosis. If a patient, on laparotomy, is found to have a few metastases in the liver without hepatic dysfunction or hard, irremovable retroperitoneal lymph nodes, one may still proceed with the removal of a cancer of the stomach, colon, or rectum, because experience has shown that gastric, colonic or rectal resection is the best palliative measure for such cancers, admittedly incurable though they are. Here again, clinical judgment must influence one's decision, as nothing is gained by enabling a patient to live longer and suffer more. The measure of palliation accomplished by such resection is not necessarily the longer duration of life but the degree of freedom from distress. A lobectomy for a solitary metastasis in the lung in a patient who had experienced an amputation of an extremity for osteogenic sarcoma would have been considered meddling surgery a decade ago, but not in the light of the present day viewpoint.

### Involvement of Multiple Organs by Cancer

One of the outstanding achievements in the surgical treatment of gastro-intestinal cancer is

the unexpected good result which frequently follows the removal of cancers that have become adherent to adjacent organs and are at first examination seemingly inoperable. The explanation lies in the fact that cancers of the stomach, colon, and rectum, which are papillary or polypoid in character, often become grossly infected and, as a consequence, the organ becomes adherent to adjacent viscera or structures. These tumors appear technically irremovable and give the false impression of extension of the cancer beyond the confines of the organ primarily involved. By perseverance and meticulous dissection, associated at times with the sacrifice of a portion or the whole of the adjacent organ, the surgeon can often remove this growth successfully. The subsequent pathological report, in many instances, will reveal that the cancer itself had not extended to involve the neighboring organ, and that the adhesions were of inflammatory character; in fact, the cancer itself may be classified as of relatively low-grade malignancy. I have known of numerous instances in which complications of this character were found, and no regional metastases to nodes were discovered on careful microscopical survey. These facts encourage one to attempt by every means possible the removal of cancers which are adherent to any structures that may be sacrificed by excision in continuity with the organ involved.

#### *Stomach*

Although total gastrectomy had been attempted within a few years after Billroth's initial partial gastrectomy for cancer, the operation did not find popular acceptance by gastric surgeons until the past decade. It is now known that the entire stomach can be safely removed and the individual live thereafter without too great inconvenience and without too disturbing metabolic changes. On the Gastric Service of the Memorial Hospital, we have performed approximately 100 total gastrectomies for cancer and approximately 100 transthoracic resections of the lower esophagus and upper end of the stomach for cancers of the proximal gastric segment. In past years, the very location of the cancer juxtaposed to the cardia was sufficient to cause it to be pronounced inoperable in many hospitals, in consequence of which 8 to 10 percent of all patients with gastric cancer were denied surgical intervention merely because of the accidental location of the cancer near the region of the cardiac orifice. The extension of the cancer to involve the esophagus, both below and above the diaphragm, called for a popularization of the operation of transthoracic, transdiaphragmatic esophago-gastrectomy. This procedure has now

been well established. The end-results of this operation and the preoperative and postoperative management are so improved that these cancers can no longer be classified as inoperable because of location only. In these cases of extremely radical surgical removal of gastric cancers, we have found many occasions to remove adjacent organs in whole or in part. Segments of the diaphragm, the entire spleen, variable portions of the pancreas, part of the left lobe of the liver adherent to or invaded by the cancer, and large segments of the transverse colon have all been removed in continuity with the entire stomach on numerous occasions. In the earlier years of gastric surgery, any one of these complications, i.e., the adherence of such organs to the stomach, would have constituted an excuse for classifying the cancer in that particular patient as irremovable.

#### *Colon*

We now know that the colon may be removed in its entirety, as is done in patients with multiple or diffuse polyposis of the bowel or in those with multiple colonic cancers. Many cancers of the colon—particularly of the papillary type, which are commonly infected—are adherent to adjacent organs. This does not constitute a state of inoperability because in the majority of cases, these neighboring viscera may be removed safely with the colon. For example, there have been numerous instances in which we have resected a large segment of the colon, combined with hysterectomy in the female, or a wide segment of the pelvic colon with partial or total cystectomy in the male, or the splenic flexure with an adherent spleen. There have been numerous cases in our series with the transverse colon adherent to the stomach, and in some instances with perforation and fistula formation, so that colectomy was combined with subtotal gastrectomy in order to remove the cancer in toto.

#### *Rectum*

Many errors are made in diagnosing a rectal cancer as technically inoperable because of fixation as judged by digital examination of the cancer through the rectum. Many cancers which appear to be firmly adherent in the hollow of the sacrum or to the lateral wall of the pelvis when felt by combined recto-abdominal palpation can be successfully removed at the time of laparotomy. Unless the cancer is so completely fixed as to cause the so-called frozen pelvis, and providing the patient does not have evidence of distant metastases in the liver or in signal nodes, these patients may profitably be explored. This sometimes re-



sults in the happy discovery that the adherence of the cancer is a pseudo-fixation that can readily be relieved by dissection. Cancers of the rectum, because of their tendency to infection and extension through the wall of the bowel, become adherent to adjacent pelvic viscera such as the urinary bladder or the uterus. Under these circumstances, these organs should be removed in part or in whole, depending upon the extent and particular site of involvement.

#### *Tumors Primary in or Adherent to the Bony Pelvis*

The involvement of the *os innominatum*, with the exception of the iliac crest, by a primary malignant tumor of bone, had in the past almost invariably been considered as inoperable. Furthermore, cancers primary on the lower extremities, such as synoviomias, malignant melanomas, and epitheliomas, after metastasis to the groin and extension into the iliac nodes with adherence, were deemed inoperable because of the extent of the disease. Primary malignant bone tumors of the pelvic bone and tumors in the region of the buttock, such as sarcomas of the soft somatic tissues that are adherent, and metastasizing melanomas and epitheliomas that involve the iliac nodes with adherence, are now being treated by such a radical procedure as hemipelvectomy, or the so-called interilio-abdominal amputation. We have performed a series of 20 hemipelvectomies at the Memorial Hospital, based on these indications, without an operative death.

#### *Pelvic Evisceration for Advanced Pelvic Cancers*

General surgeons and gastro-intestinal surgeons operating on cancers of the rectum have, on many occasions, performed a partial vaginectomy, together with an abdominoperineal rectal resection for those rectal cancers that involve the rectovaginal septum. Gynecologists, per contra, and almost without exception, have been prone to classify all vaginal cancers as inoperable. The cause of inoperability has even been listed on the patient's chart as due to invasion of the rectovaginal septum, with the statement that vaginectomy could not be done without entering the rectum. From the patient's point of view, a death from cancer of the vagina is just as bad as death from rectal cancer, and a permanent terminal abdominal colostomy for cancer of the vagina should be just as acceptable as it is for cancer of the rectum. The same philosophical concept obtains for advanced cancers of the urinary bladder, rectum and uterine cervix. Cervical cancers invading the rectum and bladder may be removed by exenteration of all

viscera within the pelvis combined with bilateral iliac and obturator lymph node dissection. The ureters are disposed by ureterocolic anastomoses resulting in a functioning but unpleasant "wet" colostomy, or separate bilateral cutaneous ureterostomies, again a nuisance but with less morbidity and lowered mortality. The rectum, uterus, vagina and urinary bladder may be removed en masse, or the bladder, uterus and vagina alone, or the rectum, uterus and vagina alone, depending on the regional type of cancer and extent of invasion. The pelvic cavity is left denuded of peritoneum without fear of untoward consequences. The comforting loss of pain, the relief from hemorrhages, sepsis, tenesmus and the indignities of uncontrollable fistulae more than compensate for the perversion of excretory habits. After all, the human residue is happier by the exchange of discomforts.

#### *Successful Secondary Operations for Cancer*

The surgeon is frequently confronted with patients and their relatives who relate the story of exploratory laparotomy followed by pronouncement of inoperability and, in consequence, incurability of the cancer. They usually importune the next surgeon seen, and perhaps many others, to intervene again, not being willing to accept the opinion and judgment of the initial surgeon, who had an opportunity to study the extent of the cancer at the time of laparotomy. Physical examination of such patients, after their discharge from other hospitals, may often permit the later surgical consultant to agree in an obvious diagnosis of inoperability. However, in the absence of physical signs of inoperability, one is sometimes justified in sending a note of inquiry to the surgeon, requesting a copy of the operative findings. If the reasons for not resecting the cancer were given as distant metastases, for example, in the liver, or diffuse peritoneal carcinosis, then the indications of inoperability must be considered absolute. But if the operative findings are listed, indicating that the decision not to remove the cancer was based on technical difficulties, there may exist a suitable excuse for a second attempt at removal. It may seem presumptuous to attempt an operation in the face of a previous failure by one who has had an opportunity to inspect the cancer and its extent at the time of laparotomy, but in some cases, the wisdom of this decision seems apparent. Such secondary operations should be taken with a full understanding by the family that it might not be possible to complete the operation successfully. In eight of nine such secondary operations for

supposed inoperable cancers, we have been successful in the radical extirpation of the neoplasm.

### Epicrisis

I realize that the surgeon who attempts these radical procedures with some inevitable failures in a small community may be subjected to considerable criticism, whereas in a city the size of New York and in a specialized cancer hospital, he may be forgiven for his failures. This fact may be a practical deterrent to the application of the fundamental philosophy I have been discussing, but it does not detract one whit from its essential validity. It is your responsibility as doctors, as surgeons, to adopt a positive attitude for the treatment of patients with advanced cancer. You must be sure that your refusal to operate upon a patient with cancer is based on the generalization of the disease and not on mere technical difficulties, local extensiveness of the lesion, advanced age, or poor general physical condition of the patient. In short, if it is humanly possible to remove a given cancer, it is your duty to remove it, in virtually every case.

### Bibliography

1. Pack, G. T., McNeer, G., and Coley, B. L.: Interscapulothoracic Amputation for Malignant Tumors of the Upper Extremity. *A Report of Thirty-one Consecutive Cases, Surg., Gynec. & Obstet.* 74:161 (Feb.) 1942.
2. Pack, G. T. and Rekers, P.: The Management of Malignant Tumors in the Groin, *Am. J. Surg.* 56:545 (June) 1942.
3. Pack, G. T. and McNeer, G.: Total Gastrectomy for Cancer. A Collective Review of the Literature and an Original Report of Twenty Cases, *Surg., Gynec. and Obstet.* 77:265 (Oct.) 1943.
4. Pack, G. T.: The Palliative Point of View about Cancer, *Radiology* 41:591 (Dec.) 1943.
5. Pack, G. T.: On the Pronouncement of Cancer, *Surg., Gynec., and Obstet.* 78:214 (Feb.) 1944.
6. Pack, G. T., Scharnagel, I., and Morfit, M.: The Principle of Excision and Dissection in Continuity for Primary and Metastatic Melanoma of the Skin, *Surgery* 17:849 (June) 1945.
7. Pack, G. and Ehrlich, H. E.: Exarticulation of the Lower Extremities for Malignant Tumors. Hip Joint Disarticulation (With and Without Deep Iliac Dissection) and Sacro-iliac Disarticulation (Hemipelvectomy), *Ann. Surg.* 123:965 (June) 1946; 124:1 (July) 1946.
8. Pack, G. T., McNeer, G., and Booher, R. J.: Principles Governing Total Gastrectomy, *Arch. Surg.* 55:457 (Oct.) 1947.
9. Pack, G. T., and McNeer, G.: Surgical Treatment of Cancers of the Gastric Cardia, *Surgery* 23:976 (June) 1948.
10. Pack, G. T.: The Definition of Inoperability of Cancer, *Ann. Surg.* 127:1105 (June) 1948.
11. Pack, G. T., Editor: *Cancer of the Esophagus and Gastric Cardia.* C. V. Mosby Co., St. Louis, Mo., 1949, p. 188.

# A Study of Thyroid Disease in Hawaii

G. C. FREEMAN, M.D.

HONOLULU

IT has long been the impression of the Surgical Department of The Clinic that about two-thirds of the patients coming under its care for thyroid disease had primary hyperthyroidism (Graves' disease), and that the remaining one-third had various other surgical lesions, the majority of which were classified as "adenomas." The policy of prophylactic removal of all thyroid nodules has been steadily adhered to during the period covered by this study on the assumption that most, if not all, were true neoplasms.

However, as this study progressed, it became apparent that this general impression would have to be revised, and that a review of the pathological material was essential to a proper evaluation of the cases available for study. This was made especially necessary by the fact that the reports on the records exhibited considerable variation in the terminology applied to the lesions found.

Each case record, therefore, has been studied according to the symptomatology, the physical findings, the operative findings, the gross pathological description and the histologic picture. For this last phase, microscopic slides of each case were obtained from the files of The Clinic or the

hospital concerned, and these were reviewed by the author with the assistance and advice of Dr. I. L. Tilden. No diagnosis has been made and no case included unless there was available adequate microscopic material from which to make a diagnosis. In order that the reader may have a complete understanding of our interpretation of the pathological material, I will discuss the criteria that we have used in classifying the cases.



DR. FREEMAN

## Pathology

We have utilized the classification followed by Shields Warren<sup>1</sup> and have separated our cases into various categories he has suggested. The classification of thyroid pathology given in the accompanying chart (Table 1) should help to clear up the confusion in terminology which exists in the minds of many clinicians and surgeons. Each category will be discussed briefly and certain points emphasized, both clinical and pathological, that are important in arriving at such a division. A complete discussion of all of the pathological features of each entity is not possible at this time.

### Primary Hyperplasia

Primary hyperplasia, clinically known as primary hyperthyroidism, toxic diffuse goiter, etc., exhibits a fairly uniform pathologic picture. The gland of primary hyperthyroidism is diffusely and symmetrically enlarged, and has a uniform homogeneous appearance on cut section. The fundamental microscopic change is the hyperplasia of the epithelium of the thyroid follicle. By that is meant an increase in the cells, both in size and number, and it can be shown clinically by labora-

TABLE 1.—*Classification of Thyroid Pathology*  
(Condensed from Shields Warren)

- I. **Primary hyperplasia: primary hyperthyroidism, diffuse toxic goiter, exophthalmic goiter, Graves' disease.**
- II. **Thyroiditis**
  - A. Acute inflammation
  - B. Chronic inflammation
  - C. Riedel's struma—ligneous thyroiditis
  - D. Hashimata's disease—struma lymphomatosa
- III. **Multiple callad adenomata: endemic goiter, callad goiter, non-toxic nodular goiter.**
- IV. **Tumors**
  - A. Benign adenoma
    1. Embryonal
    2. Faetal
    3. Simple or callad
    4. Papillary cystadenoma
  - B. Malignant
    1. Low-grade or potentially malignant
      - A. Any adenoma with vascular invasion
      - B. Papillary cystadenoma
    2. Moderate malignancy
      - A. Papillary adenocarcinoma
      - B. Alveolar adenocarcinoma
      - C. Hurthle cell adenocarcinoma
    3. High-grade malignancy
      - A. Small cell carcinoma (carcinoma simplex)
      - B. Giant cell carcinoma
      - C. Epidermoid carcinoma
      - D. Fibrosarcoma
      - E. Malignant lymphoma

From the Department of Surgery, The Clinic, Honolulu. Read before the 60th annual meeting of the Hawaii Territorial Medical Association, Hilo, Hawaii, May 6, 1950.

<sup>1</sup> Lahey, F. H., Hare, H. F. and Warren, S.: Carcinoma of the Thyroid, Ann. Surg. 112:977 (Dec.) 1940.



tory tests that there is a corresponding increase in thyroid activity. The precise picture seen under the microscope after surgical resection of the gland depends upon the severity of the disease and the extent and type of preoperative treatment previously given to the patient.

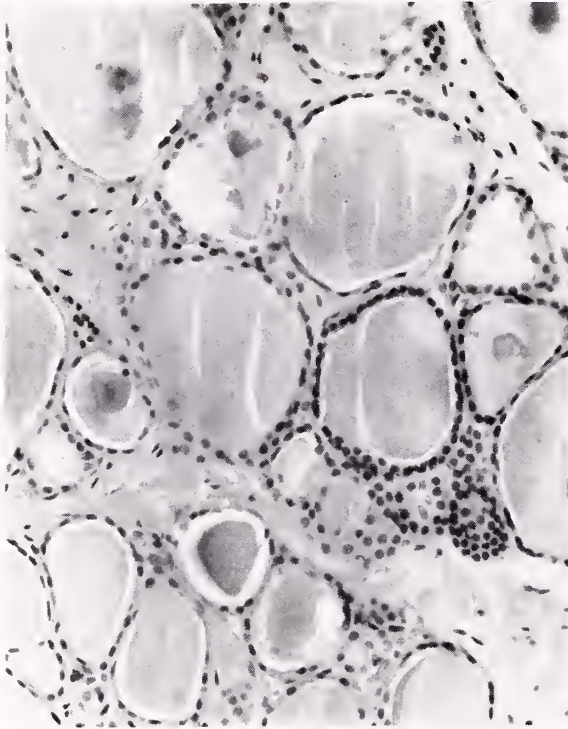


Fig. 1. Normal thyroid. Hematoxylin and eosin,  $\times 265$ .

### *Thyroiditis*

Inflammatory reactions in the thyroid gland—thyroiditis—may take the usual acute suppurative or chronic form, but these types are seldom treated surgically. However, there are two types of chronic thyroiditis which have a characteristic pathologic picture, although they are not accepted by all authors as etiological entities. For our purpose, it is sufficient to state that Riedel's struma, or ligneous thyroiditis, is characterized by an almost complete replacement of thyroid epithelium by minimal infiltration of inflammatory cells, and marked fibrosis through part or all of the gland, giving it its characteristic woody hardness (Fig. 2). In Hashimoto's disease, or struma lymphomatosa, the gland is symmetrically and moderately enlarged and has a pebbly, finely nodular surface with a firm rubbery consistency. Grossly, on section, there is a characteristic pearly gray finely nodular surface with little or no colloid. Microscopically, there is a distinctive picture showing extensive infiltration with lymphocytes,

formation of lymphoid follicles, and a peculiar eosinophilic exhausted appearance of the individual cells of the epithelium (Fig. 3).

### *Colloid "Adenomatous" Goiter*

The third category listed in the classification is also known by various names, ranging from such geographic terms as "endemic goiter" to the inclusive, descriptive title suggested by Warren, "multiple colloid adenomatous goiter." This title includes the major gross features of the entity: that it is a goiter, or thyroid enlargement; that its predominate substance is colloid; that it has multiple nodules; and that it has an adenoma-like appearance. If it were only euphonious to do so, it would perhaps be better to use the word "adenomatoid" instead of "adenomatous." This would remove entirely from the title the suspicion that the entity is "related to adenoma" which by definition is a "neoplasm of glandular epithelium . . ." It would, instead, make it clear that the changes merely "resemble an adenoma." The changes found in multiple colloid adenomatous goiter are partly a result of the many hormonal and environmental influences to which the thyroid gland is

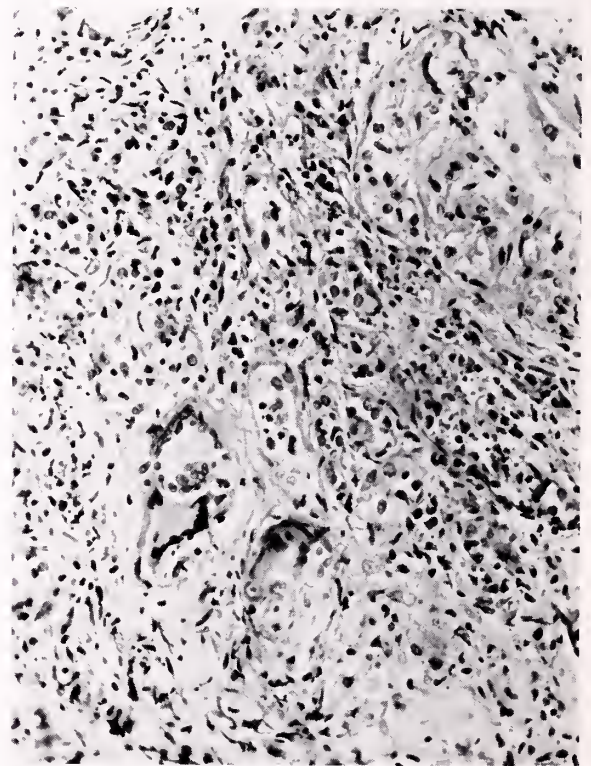


Fig. 2. Riedel's struma, showing destruction of thyroid tissue with replacement by lymphocytes and fibroblasts. Giant cells are present and in the upper right hand corner there is a pseudotubercle centering around a destroyed follicle. Hematoxylin and eosin,  $\times 265$ .





Fig. 3. Hashimoto's disease: The thyroid tissue has been largely destroyed and replaced by lymphoid tissue with prominent germinal centers. The colloid is missing for the most part in those follicles which still remain, and the lining epithelium stains in an acidophilic fashion. Hematoxylin and eosin,  $\times 120$ .

subject, but it should be clearly understood that they merely resemble adenomas and are not truly neoplastic.

The gland of multiple colloid adenomatous goiter varies greatly in size, shape and consistency, both in its over-all appearance and also in the appearance of its individual nodules. In fact, one can say that it is the variegated appearance of the gland in situ, on section, and under the microscope which is its most distinguishing feature. On physical examination and at operation, there may be gross irregularity and asymmetry of the outline of the gland. The component nodules may vary in size from a millimeter or two up to several centimeters. The cut surface characteristically shows large amounts of gelatinous colloid, but there may be cysts, areas of fibrosis, hemorrhage, degeneration and calcification. In Fig. 4, three small thyroid nodules can be seen and it is easy to visualize these gradually becoming larger over a period of years by recurring episodes of hyperplasia and involution with later degeneration and hemorrhage.

### *True Adenoma*

The greatest confusion in the classification of thyroid disease occurs in the separation of cases of multiple colloid adenomatous goiter from those with true adenomas. This distinction is of more than academic importance. Most authors agree that carcinoma of the thyroid gland arises in a pre-existing adenoma in the majority of cases. Although most carcinomas have such an origin in adenomas, not all adenomas become actually malignant, the figure quoted ranging from 3 to 10 per cent. However, it is impossible to predict clinically which are or will become malignant in much the same way that it is impossible to tell which mass in the breast or which polyp in the colon is malignant or has malignant potentialities.

In making the distinction between multiple colloid adenomatous goiter and true adenoma, it is important to remember that the former is not a neoplastic process but is the end result of the play of various factors we have already discussed, and is brought about by a process of alternating hyperplasia and involution, either localized to one area of the gland or present diffusely throughout it. Superimposed are the effects of hemorrhage and

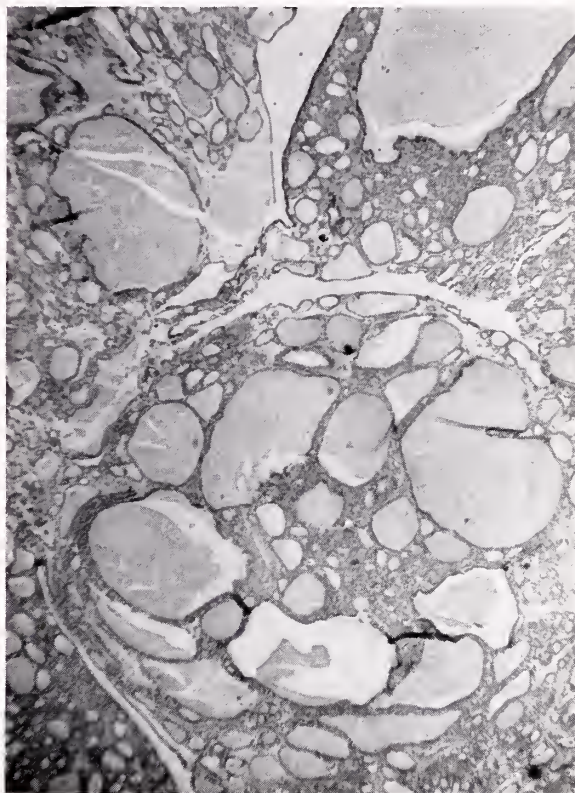


Fig. 4. Multiple colloid adenomatous goiter, showing the formation of poorly defined nodules made up in part at least of extremely large follicles filled with colloid. Hematoxylin and eosin,  $\times 45$ .



degeneration. The multiplicity of lesions is most important in separating this process from the adenomas, which are usually single. There are other features of adenomas discernible grossly which are very important in separating them from multiple colloid adenomatous goiter. In addition to being usually single, they have a distinct and true capsule which separates them from the surrounding somewhat compressed normal thyroid tissue. The cut surface of the tumor has a uniform appearance and the tumor tissue usually is obviously of a different character from the normal thyroid (Fig. 5). Finally, the various types of

found it very difficult, from slides alone, to determine whether a given lesion was a true colloid adenoma or a well-defined thyroid nodule without degeneration. Some authors question the existence of such an entity as colloid adenoma. In studying our cases, we found that the microscopic picture of an adenoma was frequently mixed and selection of the proper type was based on the predominant picture seen.

### *Carcinoma*

In his classification of carcinomas, Warren has separated them into those of low, moderate and high-grade malignancy. In the low grade, or potentially malignant, he includes any of the above-mentioned adenomas which manifest blood or lymph vessel invasion, demonstrable conclusively only with special staining technics. The papillary adenoma is regarded as potentially malignant. In our series, 11 out of 12 papillary tumors were already definite carcinomas (Fig. 9) and belonged

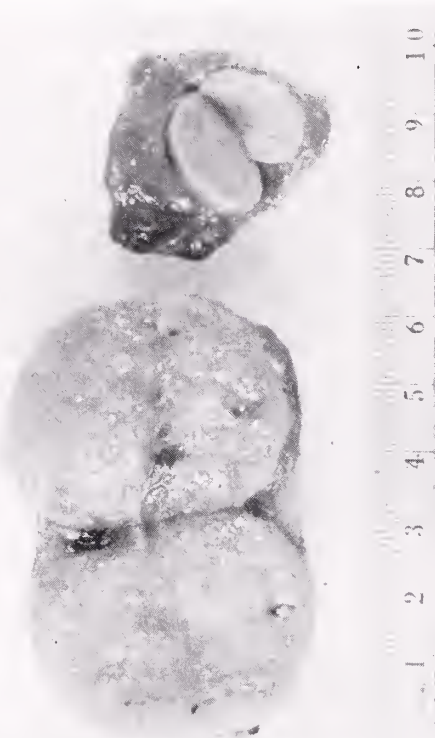


Fig. 5. Two true adenomas removed at the same operation from the same patient. The larger microscopically was a colloid type of adenoma. The smaller was predominantly embryonal in appearance. Note that each has a discrete, distinct capsule separating it from the surrounding normal thyroid tissue.

adenomas have a characteristic microscopic appearance, although they are indistinguishable grossly.

The characteristic appearance of fetal adenoma consists of small clusters of acini embedded in a myxomatous stroma (Fig. 6). The embryonal adenoma (Fig. 7) is composed of solid columns or tubules of closely packed uniform cells. The simple or colloid adenoma (Fig. 8) is composed of more or less mature-appearing follicles containing colloid. In the study of our cases we sometimes

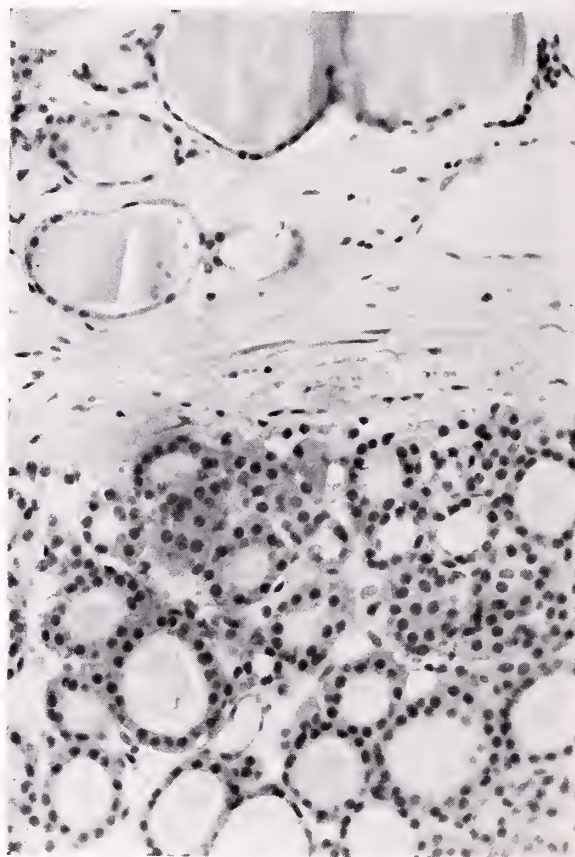


Fig. 6. Fetal adenoma: Such tumors are made up of small micro follicles which are devoid of colloid and there is usually abundant interfollicular material. The capsule is shown separating the tumor below from normal thyroid above. Hematoxylin and eosin,  $\times 265$ .



in the group of moderate malignancy. Also included in the moderate group is the alveolar adenocarcinoma (Fig. 10). The highly malignant tumors of the thyroid are those which exhibit varying degrees of anaplasia or metaplasia, such as the small cell, giant cell and epidermoid carcinomas, and those unusual growths, fibrosarcomas and malignant lymphomas.

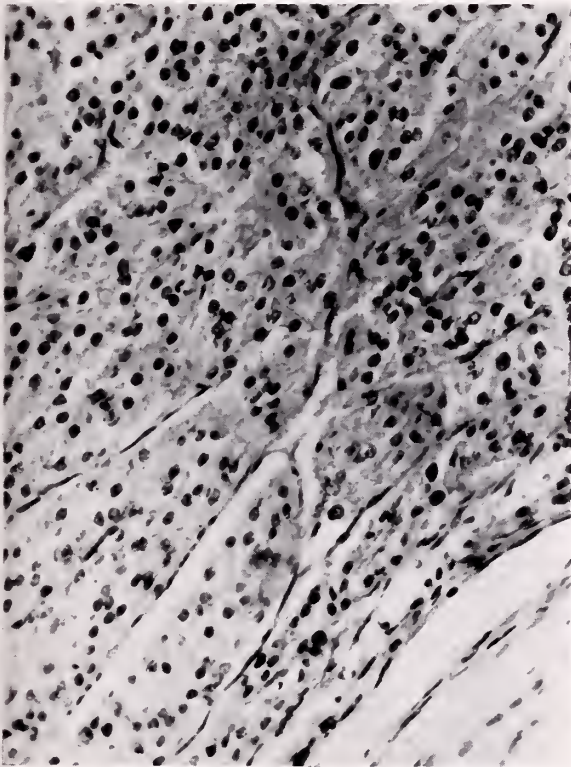


Fig. 7. Embryonal adenoma, showing a solid tumor made up of cells arranged in alveoli and cords. The cells are uniform in size and shape and show none of the characteristics of malignancy. Even with a benign histologic picture as shown here, some of these tumors have the power of invasion, in which case they should be called alveolar carcinoma. Hematoxylin and eosin,  $\times 265$ .

Analysis

In this study, 423 clinical case records from the files of The Clinic were reviewed (Table 2). This represents all patients who had undergone surgery on the thyroid gland during the 20 years from 1930 to January 1, 1950. Of these, 250 had the typical clinical picture and operative findings of primary hyperthyroidism, and on the record there was confirmation of the diagnosis in the pathological report. The microscopic slides of these patients were not reviewed. Of the remaining 173 patients not having primary hyperthyroidism, 11 were discarded because we were unable to obtain satisfactory material for study.

Thus, 162 patients are included in this clinical and pathological review, shown in Table 3. Six of these had two separate lesions making a total of 168 separate lesions diagnosed. The sex incidence of all patients in the review was predominantly female in a ratio of more than 4 to 1, there being 133 females and 29 males.

TABLE 2.—Material Studied

Of 423 patients who had operations on their thyroid gland	
No. of patients with primary hyperthyroidism, clinical record only reviewed.....	250—59.1%
No. of patients with lesions other than primary hyperthyroidism—clinical record and pathological material studied.....	162—38.3%
No. of patients discarded from series because of inadequate material for study.....	11
Total No. of cases reviewed.....	423

The 168 diagnoses made are shown in Table 3. There is a surprisingly high incidence of thyroiditis—3 cases of Riedel's struma and 10 of Hashimoto's disease. This represents an incidence for Hashimoto's disease of 2.3 per cent of the 423 patients operated upon, about ten times that reported elsewhere.<sup>2</sup> Of the 10 patients with Hashimoto's disease, only 3 were Japanese and the

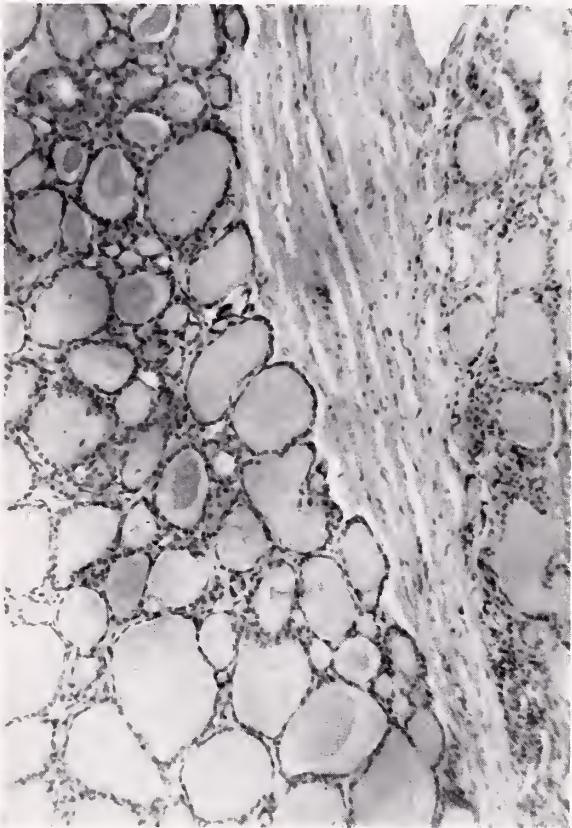


Fig. 8. Colloid adenoma: The tumor (left) is made up of follicles which are quite similar to the normal thyroid follicles (right), except that they stain somewhat differently. Note thick fibrous capsule. Hematoxylin and eosin,  $\times 120$ .

<sup>2</sup> Marshall, S. F., Meissner, W. A., and Smith, D. C.: Chronic Thyroiditis, New Eng. J. Med. 238:758 (May 27) 1948.



remainder predominantly Caucasian. All 10 patients were females.

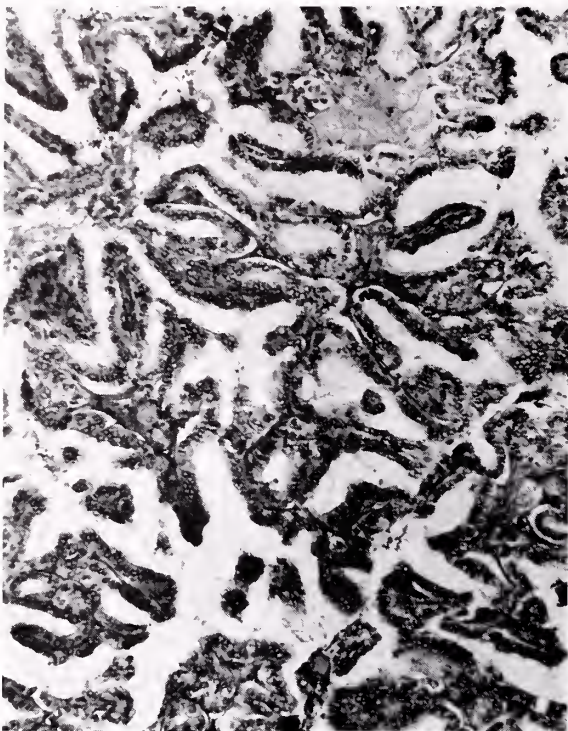


Fig. 9. Papillary carcinoma, showing characteristic papillary structure. The cells are uniform in size and shape and show little evidence of activity. However, the malignant papillary tumors show evidence of invasion of capsule, lymphatics or blood vessels. Hematoxylin and eosin,  $\times 80$ .

TABLE 3.—Gross Classification of Lesions in 162 Patients with Thyroid Lesions other than Graves' Disease

In 162 patients studied:		
168 separate lesions diagnosed		
6 patients had two distinct lesions		
Of 168 lesions diagnosed:		
I. Thyroiditis	13—	7.7%
Hashimoto's disease	10	
(2.3% of 423 patients)		
Riedel's struma	3	
II. Multiple colloid adenomatous goiter	111—	66.0%
III. Neoplasms	44—	26.2%
Total	168	

The most surprising fact brought to light by this study was the high incidence of multiple colloid adenomatous goiter. Of the 423 case records reviewed, and the 162 patients whose study included a review of the histology, 111 diagnoses of multiple colloid adenomatous goiter were made. This is exactly 66 per cent of the 168 diagnoses made after study of all available microscopic sections. There were a few instances in which the distinction between a true colloid adenoma and a nodule of multiple colloid adenomatous goiter was uncertain, but in most cases there was no hesitancy in separating the neoplastic from the non-neoplastic lesions. Some statistical data regarding these 111 patients are shown in Table 4.

TABLE 4.—One Hundred and Eleven Cases of Multiple Colloid Adenomatous Goiter

Males	18
Females	93
Age Group:	
To 29 years	21
30 to 39 years	31
40 to 49 years	24
50 to 59 years	14
Over 60 years	2
Unknown	19
Racial or national extraction:	
Caucasian	60
Japanese	10
Chinese	11
Part Hawaiian	8
Filipino	4
Other	1
Unknown	17

If the 13 cases of thyroiditis are excluded, there are left 149 nodular thyroids of which 111, or 75 per cent, showed the changes characteristic of multiple colloid adenomatous goiter and 40 showed true neoplasms. Two of the multiple colloid adenomatous goiters also had incidental fetal adenomas.

In these 149 nodular thyroids, there were 14 carcinomas (9.4 per cent) and 30 adenomas (20 per cent).

As indicated in Table 5, 44 neoplasms of the thyroid gland were found in 40 patients. Of these, 30 (68 per cent) were benign and 14 (32 percent) were malignant. As would be expected, fetal adenoma—present in 13 patients—was the most common benign neoplasm, but embryonal adenoma was almost as common, being present in 10 patients. Six colloid, or simple adenomas, and one papillary adenoma were found.

TABLE 5.—Thyroid Neoplasms Observed

Of 44 neoplasms diagnosed in 40 patients	
I. Adenomata:	
Fetal	13
Embryonal	10
Colloid	6
Papillary	1
Total	30—68%
II. Cacinomata:	
Papillary	11
Alveolar	3
Total	14—32%

Of the 14 carcinomas, all belonged to the moderately malignant group. Eleven were papillary adenocarcinomas and 3 were alveolar adenocarcinomas. No highly malignant undifferentiated tumors were found, and there were no tumors of stromal or mesodermal origin. It is important to note that 11 out of the 12 papillary tumors were already malignant at the time of surgery.

Discussion

The outstanding fact brought out by this survey is that, contrary to the expectation of the author and the commonly voiced opinion of physicians in the Territory, multiple colloid adenomatous goiter (or non-toxic nodular goiter, if you prefer) is by no means a rare disease in Hawaii. In fact, comparing its incidence with the other thyroid lesions removed by the Surgical Depart-

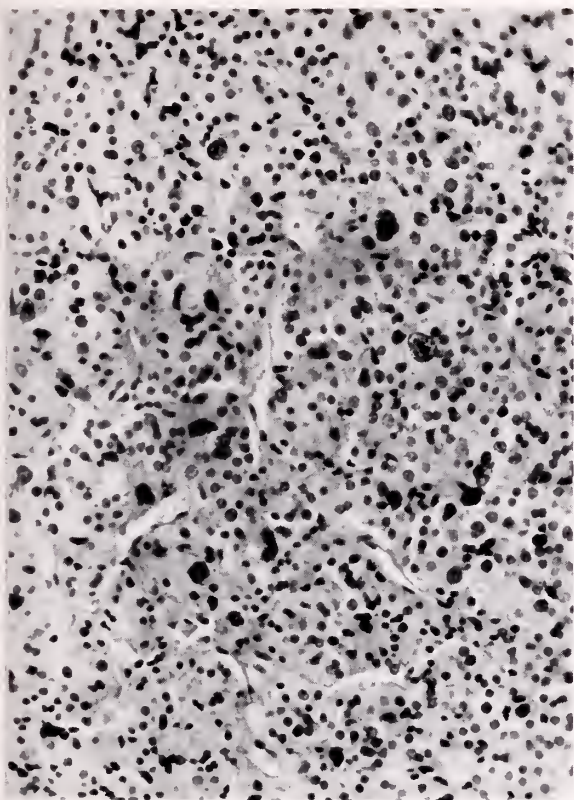


Fig. 10. Alveolar carcinoma, in which the cells are growing in solid cords and masses, and show anisocytosis, pleomorphism, hyperchromatism and other signs of malignancy. Hematoxylin and eosin,  $\times 265$ .

ment of The Clinic, it is found to be present in approximately 25 per cent of all patients operated upon and is two and one-half times as common as neoplasms of the thyroid gland (111 versus 44). It is not meant to say that Hawaii is an endemic goiter area but instead, that the incidence of "sporadic" multiple colloid adenomatous goiter is higher than most of us have realized.

This brings up the philosophy of the removal of thyroid lesions as a measure to prevent the development of cancer. The prophylactic removal of benign adenomas is frequently recommended, and the figures presented here bear out the advisability of such surgery. Two individuals had histologically benign adenomas removed and subsequently they developed metastases. Four of the 11 patients with papillary adenocarcinoma were operated upon with a preoperative and postoperative diagnosis of benign adenoma, and not until the histologic examination was made was the malignant nature of the lesions discovered. But can we separate the true adenoma from the nodular goiter on clinical evidence alone? Experience shows that we cannot do so with certainty, and that mistakes are made in both directions. Furthermore,

Cole<sup>3</sup> (and others), report that individuals with "nodular goiter" have an increased incidence of carcinoma of the thyroid as compared with those who do not. Granting that the pre-cancerous mechanism in such individuals is probably different from the mechanism in patients with previously existing benign adenomas, the conclusions to be reached are the same.

Therefore, it is my feeling that one is not justified in withholding surgery from an individual who appears to have multiple colloid adenomatous goiter, and in waiting to see what happens. All too often, what happens will be metastases, as evidenced by the fact that in 7 out of 14 of our cases of carcinoma, the lesion had already extended beyond the confines of the thyroid gland when first seen. Many carcinomas of the thyroid gland have a relatively low or moderate grade of malignancy and are amenable to early thorough surgery with or without radiotherapy as an adjunct, and the mortality of surgery of the thyroid is low. In the 162 patients reported here, there were no post-operative deaths.

### Summary and Conclusions

The incidence of multiple colloid adenomatous goiter in the population of the Hawaiian Islands is probably higher than suspected, since it occurred in over 25 per cent of 423 patients undergoing thyroid surgery at The Clinic during the past 20 years. Excluding primary hyperthyroidism, 66 per cent of the patients who had thyroid lesions removed were found to have this disease.

Thyroiditis has an unusually high incidence in the series reported. Hashimoto's disease was present in 10 patients, or 2.3 per cent, of 423 patients operated upon.

The clinical distinction of true neoplasms of the thyroid from multiple colloid adenomatous goiter is an uncertain procedure and only resection of the lesion and microscopic examination will give a definite answer regarding its nature. In this series of 149 nodular thyroids, neoplasms were present in approximately 25 per cent of cases.

The malignant potentialities of true thyroid adenomas are generally accepted; the pre-cancerous nature of multiple colloid adenomatous goiter is less well established. However, thyroid surgery for such lesions carries a negligible mortality and morbidity, and the experience recorded here indicates the advisability of prophylactic surgery for all.

<sup>3</sup> Cole, W. H., Slaughter, D. P., and Rossiter, L. J.: Potential Dangers of Nontoxic Nodular Goiter, J.A.M.A. 127:883 (Apr. 7) 1945.

The Clinic, 1020 Kapiolani St.



# Food Values of Hawaiian-Grown Fruits and Vegetables

CAREY D. MILLER, A.B., M.S.\*

HONOLULU

**M**ORE than 25 years ago I came to Hawaii on the old *Wilhelmina*, sailing from San Francisco. In those days it was a long boat trip of 7 days, and one had a chance to get acquainted with one's fellow passengers. About two days out from San Francisco, some resident of Hawaii said, "You know, of course, that the vegetables in Hawaii have so little minerals in them that we have to buy canned or fresh vegetables from the Mainland." I was a little skeptical about such a statement but found it often repeated after arriving in Hawaii, and still hear it today.

We did not follow the advice of our shipmates, however, but used as many vegetables after arriving as we could obtain. They appeared to be normal in appearance and flavor and there was no sign of chlorosis in any of the green vegetables. This seemed to indicate that their composition must be within the limits of those previously established for each species of vegetable.

For many years it has been standard practice in Hawaii to spray the pineapple plants in certain areas with iron sulphate because the pineapple is unable to utilize the iron in the soil. Other plants, such as common vegetables, growing in the same area appear to be perfectly normal. Even today, photographs of pineapple fields being sprayed with large mechanical sprayers are depicted in the national advertising of the pineapple companies. No doubt this helps to perpetuate the idea that Hawaiian vegetables are low in their mineral values. Actually, inability to utilize this ferric iron is a peculiarity of the pineapple plant.

## Experiments Comparing Hawaiian-Grown and Mainland-Grown Vegetables

In 1921, Professor J. C. Ripperton, at that time a member of the Federal Hawaii Agricultural Experiment Station and now a member of the University of Hawaii Agricultural Experiment Station, carried out a series of experiments designed to compare the mineral values of locally-grown and mainland-grown vegetables. Two experiment stations in widely separated localities

on the Mainland, the States of Washington and Virginia, cooperated and planted cabbage, beets, and beans from the same lot of seeds which were planted in two localities on Oahu. When ready for use the vegetables were harvested on the Mainland and were sent to Hawaii in order that the samples might be prepared and the analyses done exactly as they were on the locally-grown vegetables. In 1926 Professor Ripperton issued a bulletin setting forth the results of this experiment which indicated that the three vegetables from the three areas had essentially the same content of calcium, phosphorus and iron.

## A Survey of the Mineral Content of Hawaiian-Grown Vegetables

In spite of the publicity given to this work, the old statement that I had heard before I arrived in Hawaii continued to be made. About 1940, just prior to the war, the Foods and Nutrition department of the University of Hawaii Agricultural Experiment Station undertook analyses of a large number of common vegetables in Hawaii. Forty Hawaiian-grown vegetables (32 species) were analyzed. (For example, taro and taro tops would be considered as two vegetables although they are the same species.) Eighty-eight vegetable samples were analyzed in triplicate for calcium, phosphorus, and iron.

We found the calcium and phosphorus content of these 40 Hawaiian-grown vegetables to compare very favorably with average figures published for the Mainland. On the whole our values for iron were lower than the average Mainland figures, but compared favorably with iron values that had been determined where proper care had been taken to protect the samples from iron contamination.

Unless many precautions are taken at every step in the analyses, from the beginning of the preparation of the vegetables to the final colorimetric readings, contamination from dust and from rusty laboratory equipment or windows may cause large or small errors.

All analyses for this project in the Hawaii Station were carried out with extreme care and we fully believe that this accounts for our iron figures

\* Professor, Foods and Nutrition, University of Hawaii.  
Received for publication April 12, 1950. From the Hawaii Dietetic Association.

being somewhat lower than average figures from the Mainland. Reports from Mainland laboratories that exercise special precautions, invariably show lower iron values than those in tables of average food values.

### Variation in the Mineral Content of Vegetables Is the Rule, Not the Exception

We found that the calcium content of Hawaiian-grown vegetables might vary by as much as 90 percent, between maximum and minimum values for one species. The variation between the maximum and minimum values of iron for the same species varied even more widely, from 13 to 200 percent. As stated previously, this is not an exception but the rule, and has been noted by other workers for vegetables grown in one locality. Two scientists in Colorado in 1938 collected a large amount of data from various sections in the United States and showed that a number of vegetables varied more than 200 percent in their content of calcium, phosphorus and iron.

### Factors That Affect the Nutritive Value of Vegetables

There are many factors which may affect the mineral content of any one species of vegetable. Some of the most important are variety, maturity, size, soil, fertilizer, and finally, cooking, freezing, and canning. The housewife, by poor methods of cooking, can cause losses in mineral values which will exceed the variations which may occur as a result of all other factors.

Vitamins are even more liable to losses and to variations from the causes listed above than are the minerals. In addition, such factors as the time elapsing between harvesting and the use of vegetables, improper storage, and lack of refrigeration, may result in loss of vitamins but not of minerals.

### What the Doctor as Well as the Homemaker Needs to Know About Preserving the Nutritive Value of Vegetables and Fruits

A few practical suggestions for retaining the nutritive value of fruits and vegetables are as follows:

1. Use fruits and vegetables as soon after harvesting as possible. Avoid long storage, as even during refrigeration some of the vitamins are gradually destroyed. Store at a low temperature, where practicable, using tight metal containers or plastic bags to prevent evaporation.
2. Do not soak pared and cut vegetables in water, as soaking extracts the water-soluble vitamins.
3. Do not use soda to preserve the color of vegetables or shorten the cooking time, as soda destroys the vitamins.
4. Use as little water as practicable for cooking vegetables.

5. Do not discard the water in which vegetables are cooked. Serve it with the vegetable or use it for soups or gravies. It is better to have no water to discard.

6. Bring foods to the boiling point as rapidly as possible.

7. Do not defrost frozen vegetables before cooking. Start the cooking of frozen vegetables while they are still frozen, using a small amount of water, and serve the liquid with the vegetable. Serve frozen fruits immediately after thawing.

8. Serve foods as soon as possible after they are cooked. Do not over-cook, and avoid reheating foods when possible. Cooked foods stored in the refrigerator for a day or more and then reheated have much reduced vitamin values.



PROF. MILLER

### Are Canned and Frozen Vegetables as Nutritious as Fresh?

People often ask if canned foods are as good as fresh. The natural variations in the nutritive value of vegetables have already been emphasized. Authentic data obtained from many laboratories on the Mainland indicate that some foods retain their nutrients well and others lose large proportions of their vitamins during canning and storage. When the liquid of such vegetables as canned peas is discarded,  $\frac{1}{3}$  of the thiamine and  $\frac{1}{4}$  to  $\frac{1}{2}$  of the different minerals may be lost. A long series of experiments has shown that when canned foods are stored at temperatures of 80° F. and above, the losses in vitamin content are 20 percent or more, and that after storage at a temperature of 100° F. for as long as a year, only  $\frac{1}{3}$  of the original vitamins may remain. Displaying canned goods in show windows that receive direct sunlight for many hours of the day and storing them in hot warehouses must cause the destruction of considerable vitamins.

Frozen foods, like canned, may be of high nutritive value but there is ample scientific work to demonstrate that frozen foods, especially vegetables, lose some of their nutrients in the blanching process prior to freezing, and that storage even at very low temperatures permits a gradual but definite decrease in the vitamin content. An acid vegetable, such as the tomato, retains its nutrients especially well during canning and storage and concentrated orange juice has been shown to retain its ascorbic acid for almost a year.



### Hawaiian Fruits as Sources of Ascorbic Acid

In Hawaii, some people look down upon papayas, guavas and the common mango and the family spends precious food dollars for apples and California pears that could well be spent otherwise. Oranges have been so greatly extolled for their vitamin content that many people feel that no diet, especially one for children, can yield a proper supply of ascorbic acid (vitamin C) without them. Physicians can point out that fresh papaya is an extremely valuable source of ascorbic acid, having as a rule per unit of weight approximately twice the vitamin C of oranges and grapefruit.

### Are Fruit Juices and Nectars Reliable Sources of Ascorbic Acid?

Because there are no Territorial or Federal standards for the vitamin content of fruit juices and nectars, imported products and local papaya and guava nectars cannot be depended upon to furnish the amount of vitamin C that children may need in their diet. The Foods and Nutrition Department has found the ascorbic acid content of the papaya nectars on the market to be variable, ranging from 10 to 40 mg. per 100 cc., and more of them are in the low ranges than in the high. When physicians recommend papaya juice for infants or small children, they should specify that it be prepared at home from fresh mashed papaya that may be diluted with water just before feeding. The low values found to date for both papaya and guava canned juices and nectars are the result of several factors, the two most important probably being the use of copper equipment, which catalyzes the destruction of vitamin C. and

the dilution of the original product with water to make it into a drink of satisfactory consistency.

Two technical bulletins published by the University of Hawaii Agricultural Experiment Station, which give information on the nutritive value of local foods, are:

Technical Bulletin No. 5, Hawaiian-Grown Vegetables: Proximate Composition; Calcium, Phosphorus, Total Iron, Available Iron, and Oxalate Content—March 1947.

Technical Bulletin No. 6, Vitamin Values of Foods in Hawaii—September 1947.

### Summary

1. Vegetables grown in Hawaii contain normal quantities of minerals and vitamins and are not inferior nutritionally to Mainland vegetables.

2. The nutritive values of locally grown fruits and vegetables have been determined by hundreds of carefully conducted scientific experiments in the laboratories of the Foods and Nutrition Department of the University of Hawaii Agricultural Experiment Station.

3. Foods produced in Hawaii, as elsewhere, show large variations in their mineral and vitamin contents.

4. Papayas and guavas are superior to oranges as sources of ascorbic acid (Vitamin C) but commercially canned papaya and guava nectars and juices are unreliable sources of this vitamin.

If commercially canned guava and papaya products are to be used to supply vitamin C for infants, physicians should demand standards for these products and informative labeling.

5. Since physicians daily give advice about diet to their patients, they should inform themselves about the nutritive values of foods, and help to refute false ideas about local foods.

And then there is the one about the doctor refusing to call on the farmer any more, 'cause his ducks were most insulting.



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR • YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 • 7-8411



# Hawaii

## MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D. Editor  
LYLE G. PHILLIPS, M.D. Editorial Director  
MRS. EDITH C. BENNETT Managing Editor  
LAURENCE M. WIIG, M.D. Assistant Editor  
ROGERS LEE HILL, M.D. Advisory Board  
JAMES R. ENRIGHT, M.D. Advisory Board  
HASTINGS H. WALKER, M.D. Advisory Board  
PETE OKUMOTO, M.D. Associate Editor, Hawaii  
KEITH KUHLMAN, M.D. Associate Editor, Kauai  
E. T. SHIMOKAWA, M.D. Associate Editor, Maui

### [EDITORIALS]

#### PAN-PACIFIC SURGICAL CONGRESS—1951

**The Fifth Congress of the Pan-Pacific Surgical Association will meet in Honolulu November 10-21, 1951.**

**All countries bordering on the Pacific Ocean are cordially invited to send representatives to this meeting, where they will meet and become acquainted with prominent surgeons from many Pacific countries.**

**All surgical specialty sections will be represented on the scientific program. Breakfast round table discussions will be held daily and motion pictures on surgical subjects shown.**

#### TOXOPLASMOSIS IN HAWAII

Apparently there is clinical toxoplasmosis in Hawaii.

The causative organism of this disease, *Toxoplasma gondii*, was first described by Nicolle and Manceaux<sup>1</sup> in 1908, according to Frenkel<sup>2</sup>. The first well authenticated case in a human being was described by Janku<sup>3</sup> in 1923 in a patient from Czechoslovakia. Since then, infections in both human beings and animals have been reported from all over the world.

In its congenital or neonatal form, toxoplasmosis is characterized by a meningo-encephalitis with usually concomitant hydrocephaly, chorioretinitis, convulsions, and cerebral calcifications.

In 1944 Dr. Samuel Wishik, then chief of the Bureau of Maternal and Child Health, noting the high prevalence of chorioretinitis in island-born children, became interested in the possibility that

clinical toxoplasmosis might be the underlying cause. Local ophthalmologists actively participated in preliminary studies, and some of the patients who were x-rayed showed suspicious cerebral calcifications which also pointed to toxoplasmosis as the cause. At that time, laboratory testing for proof of clinical toxoplasmosis was a highly specialized field and was not available in the islands, so further work was not done.

The fact that Hawaii was one of the few places where proven cases of congenital toxoplasmosis had not been reported led Dr. Pauline Stitt to explore the possibilities of further proof by laboratory studies. After correspondence with Dr. Albert Sabin of Cincinnati, and Dr. Harry Feldman of Syracuse, Dr. Stitt was assured of their whole-hearted cooperation, and Dr. Feldman kindly offered the resources of his laboratory to carry out the tests. Arrangements were completed to send serum specimens of children with chorioretinopathy paired with specimens from their mothers. Specimens collected by Drs. Howard Crawford and O. D. Pinkerton were obtained and sent to Dr. Feldman's laboratory.

<sup>1</sup> Nicolle, M. M. C. and Manceaux, L.: Sur un protozoaire nouveau du gondi (*Toxoplasma n. g.*), Arch. Inst. Pasteur Tunis 4:97, 1909, cited by Frenkel<sup>2</sup>.

<sup>2</sup> Frenkel, J. K.: Pathogenesis, Diagnosis and Treatment of Human Toxoplasmosis, J. A. M. A. 140:369 (May 28) 1949.

<sup>3</sup> Janku, J.: Pathogenesis and Pathologic Anatomy of Coloboma of the Macula Lutea in an Eye of Normal Dimensions and in a Microphthalmic Eye with Parasites in the Retina, Casop. lek. cesk. 62:1021, 1052, 1081, 1111 and 1138, 1923, cited by Frenkel<sup>2</sup>.

Of the first ten bloods sent, four were positive, three in significant titers. In regard to this preliminary study which is still continuing, Dr. Feldman makes this significant remark in a personal communication to Dr. Stitt:

The one definite statement that we can make from these data is that toxoplasma *are* present in Hawaii and one should be able to find a clear-cut classical instance of congenital infection. . . .

This is a challenging subject for investigation and research by the medical men of Hawaii. Adults may get toxoplasmosis and recover without clinical signs, but when a pregnant woman acquires the disease, it is capable of traversing the placental barrier and attacking the unborn child. The result may be miscarriage, prematurity, hydrocephalus, microphthalmos, encephalitis, chorioretinopathy, or brain lesions that may lead to cerebral palsy or seizures. The link between animal reservoirs and human infection is not known, nor do we as yet know what part such infection may have in some of the major catastrophes of maternal and child health.

Besides Frenkel's article mentioned above, Dr. Sabin's article on Diagnosis and Treatment from the Transactions of the American Academy of Ophthalmology and Otolaryngology (Jan.-Feb. 1950) gives an excellent review on toxoplasmosis. J. R. E., M.D.

### CANCER SOCIETY'S CYTOLOGIC SERVICE

The Cytologic Laboratory of the Hawaii Cancer Society has been furnishing free cytologic diagnostic services to physicians of the Territory for a year, as of the end of July. A full-time, specially trained cytologic technician, Mrs. Esther Lo Chinn, stains the smears and screens them in the Cancer Society's laboratory, and they are then read, gratis, by Dr. Irvin Tilden, Dr. Frank Spencer, or Dr. Walter Quisenberry, and a report sent to the referring physician.

In the first year of operations, 4,102 smears from 2,114 patients have been submitted by 147 physicians from all 6 of the principal islands. The diagnosis of cancer has been made—or more accurately, suggested—in 25 cases, of which 8 were asymptomatic. Nineteen of these were vaginal smears, 2 pleural fluid, one from breast, one a sputum specimen, one liver aspiration and one rectal smear.

The value of this diagnostic technique in selected cases is beyond question, and up to the present, at least, the Cancer Society's method of providing this service seems eminently acceptable. The use of this procedure as an overall screening process, however, has come to be regarded by

many authorities as impractical and insufficiently productive. It has been suggested that if it were carried to its logical extreme, we would have half the world's population working full-time examining secretions from the orifices of the other half. A satisfactory compromise between this extreme, and limitation of the service to suspected cases alone, seems to have been arrived at here, and the Hawaii Cancer Society is to be complimented on having established such a worth-while community service.

### ADVERTISING VERSUS ANNOUNCEMENTS

Honolulu physicians have made a practice for many years of placing small boxed advertisements in local newspapers to announce their entry into practice, their return from mainland trips, their changes of address or of telephone number, their association with a partner, and so forth. This not infrequently surprises, and occasionally displeases, visiting physicians from areas where this is never done. But it is not an improper practice, by any standards. These are not advertisements, but merely announcements; they are uniform in style; there is no competition in regard to size or conspicuousness; no claims are made in them; they are dignified by long usage and custom; and they serve the useful purpose of transmitting valuable information to large numbers of patients, and to other physicians.

The following recommendations—not regulations, but suggestions—regarding these announcements were promulgated in 1948 by the Committee on Forms of Medical Practice of the Honolulu County Medical Society:

1. **SIZE:** It is recommended that the ad be not more than two columns wide and that its depth be limited to two inches, with an allowance of an additional inch if space is needed for proper additional information.
2. **SIZE AND STYLE OF TYPE:** The type used should not be larger than 20 point and a relatively plain font is recommended. No ornamentation of the advertisement other than a simple "border" outline should be used.
3. **CONTENTS:** (a) The names of physicians may be indicated by either "Dr." or "M. D."  
 (b) No other degrees or alphabetical qualifications, such as F. A. C. S., should be employed and no memberships in professional or other organizations should be mentioned.  
 (c) No reference should be made to specialization except: (1) In announcements of the opening of a new practice, or a limitation of practice, or the inception of a new professional association; and (2) such reference should be designated by the phrase "practice limited to" rather than "specialist" or "specialty".  
 (d) The address, telephone numbers and office hours may be mentioned.  
 (e) Notices of resumption of practice (e. g., following illness, vacation or postgraduate study), or change of address or telephone number, should not contain any mention of limitation of practice or specialization.
4. **SCHEDULE OF INSERTION OF ANNOUNCEMENTS:** It is suggested that only one announcement should appear each day in any one paper for a period of not longer than one week.

Attention of Honolulu physicians is invited to item 3 (c) in the above, since it has frequently been disregarded. The statement of limitation of practice to a special field is appropriate only when it is a major purpose of the announcement. Its inclusion in announcements of return from the mainland or change of address or telephone number is gratuitous, and really constitutes a not-very-thickly-disguised form of advertising. It should not be done.

### YOUR A. M. A. DUES

The novelty of having some financial responsibility toward the American Medical Association—other than merely paying County Society dues—has some physicians puzzled.

It is not so very complicated. In 1949, members were all asked for a voluntary contribution of \$25 to help finance the national public relations campaign. Eighty-four per cent of Hawaii's physicians responded to this call.

In 1950, dues in the amount of \$25 were required of all members, in addition to their County Society dues; this sum becomes delinquent, and A. M. A. membership ends if the amount remains unpaid, on January 30, 1951. Reinstatement at any time will require payment of this sum in addition to whatever subsequent indebtedness may have been incurred.

Now the dues for 1951 have been set at \$25 again, but this time a subscription to the *Journal of the A. M. A.* is thrown in for free.

Fellowship status has always confused a lot of doctors. Its principal privileges are those of participating in the program of the Scientific Assembly of the meetings of the A. M. A.—giving or discussing papers—and of acting as an officer of, or delegate to, the national organization. It requires specific application for Fellowship status, not merely the act of subscribing to the *Journal*.

Fellowship dues for 1950 and previous years have been \$12 in addition to the membership dues. Fellowship dues for 1951 have now been set at \$2, and carry with them the additional privilege of taking any of the A. M. A. specialty journals in place of the *J. A. M. A.* Members who are not Fellows do not have this privilege: they must pay the going rate for a specialty journal if they want it.

### "PSYCHOGENIC" DOESN'T MEAN "FUNCTIONAL"

"Psychogenic," in the sense of "resulting from disturbance of the mind," is not necessarily synonymous with "functional," in the sense of "not organic." The logical opposite of "psychogenic" is "somatogenic," and the logical opposite of "functional" is "anatomic." A disease may very well be psychogenic without being functional, or functional without being psychogenic. The two words, though they are often used interchangeably, have specific and quite different meanings, and should be used with greater care.

For example, take diabetes mellitus. This is not an anatomic disorder, but a functional one; yet it is not, so far as we know, psychogenic in any instance. Peptic ulcer, on the other hand, is decidedly anatomic, and not functional; yet it is probably frequently psychogenic. Bronchial asthma, or urticaria, are both—in many instances—psychogenic *and* functional.

It's all very well to feel, as Humpty Dumpty said, that it is merely a question of who is to be the master—you, or a word. "Impenetrability," said H. Dumpty, means "There's a nice knock-down argument for you." But psychogenic means one thing, and functional means another, and who wants to emulate Humpty Dumpty? He came to a bad end, after all.

## General

Doctor: And whom did you see before you came to see me?

Patient: My pharmacist.

Doctor: And what did that D. F. tell you?

Patient: He told me to see you!



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 • 7-8411



# MEDICAL NEWS

**Intravenous pontocaine** was first mentioned in this column months ago. The original work by J. S. Horan, former Queen's Hospital intern, appears in the *Archives of Internal Medicine*, June, 1950. Relief of low back pain, arthritic pain, **asthma**, and intractable **itching** has been obtained after the administration of 20 milligrams (contents of one ampule) diluted to 10 cc. and given by vein *slowly*. This is an office procedure designed to give the same results that I.V. procaine drips do in hospital practice.

**Benemid**, a benzoic acid derivative (Sharpe and Dohme), is a new non-toxic renal blocking agent which **increases plasma levels of penicillin and of PAS** (para-aminosalicylic acid) from two to fourfold. It is given orally (0.5 gm q. 6 h) and 2 grams of Benemid have an effect equivalent to that produced by 24 grams of Carinamide. (Boger, W. P., *et al.*, *Ann. Int. Med.* 33:18 [July] 1950.)

Elliot is so impressed with **aureomycin in leprosy** of the eye that he thinks it should be intensively investigated in the other manifestations of leprosy. (*Am. J. Ophth.* 33:1029 [July] 1950.)

**Aluminum hydroxide** (Amphojel, etc.) has been widely used to alleviate and prevent the gastric upsets due to aureomycin. An astonishing pitfall in this procedure has been uncovered by Seed and Wilson. They found that aluminum hydroxide **adsorbs aureomycin** and prevents its absorption, thereby causing an *eighty per cent reduction* in the plasma concentration of aureomycin. (*Bull. Johns Hopkins Hosp.* 86:415 [June] 1950.)

Carnegie and Hewer report that **Xylocaine**, synthesized in Stockholm during World War II, is **superior to procaine** in that local anesthesia is produced faster and lasts longer, and Xylocaine has greater subcutaneous spreading power. (*Lancet*, p. 12 [July 1] 1950.)

Serious infection is the commonest mechanism by which **nuclear radiation** causes death. Miller *et al.* find that a combination of **penicillin and streptomycin** parenterally gives the highest survival rate in irradiated ani-

mals. (Miller, C. P., Hammond, C. W., and Tompkins, M., *Science* 111:719 [June 30] 1950.)

Blodgett *et al.* say that in **primary atypical pneumonia, aureomycin** is effective in rather low dosage, 250 mg. q. 4 to 6 h. (*J. A. M. A.* 143:818 [July 8] 1950.)

**d-Tubocurarine** suspended in wax-peanut-oil ("Tubadil"—Endo) is recommended by Fuller for the relief of **pain due to muscle spasm** which accompanies traumatic injuries. (*J. A. M. A.* 143:789 [July 1] 1950.)

Another antibiotic has been found effective in **amebiasis: Bacitracin**, 80,000 units, daily for ten days by mouth will cure about two-thirds of patients. The mechanism by which Bacitracin and aureomycin kill amebas is thought to be a suppression of clostridia and enterococci which may have a vital symbiotic relationship with ameba histolytica in the human bowel. (Most *et al.*, *J. A. M. A.* 143:792 [July 1] 1950.)

About 3 per cent of people are sensitive to ordinary penicillin G, and more are becoming sensitive every day. Fortunately, we now have other antibiotics, but Volini *et al.* report that **penicillin sensitive patients** can safely be given a new biosynthetic penicillin (**penicillin O**). Fifty-seven such patients were treated with penicillin O at Cook County Hospital, without reactions, and some of them were later able to resume penicillin G suggesting that penicillin O had a desensitizing effect. (*J. A. M. A.* 143:794 [July 1] 1950.)

**Hetrazan** (noted in this column a year ago as being effective in loa-loa, and African sleeping sickness) turns out to be an ideal agent for the treatment of **ascariasis**. It is superior to hexylresorcinol, the present standard agent, in that no starvation before, and no laxative after, the drug are required. The toxicity is practically nil, and dosage is low (10 mg. per kilo body wt. t. i. d. for one week). The effectiveness of this drug varies in different parts of the world: it has been found to be extremely good in the Philippines and rather poor in the Belgian Congo. (Etteldorf and Crawford, *J. A. M. A.* 143:797 [July 1] 1950.)

C. A. DOMZALSKI, JR., M. D.

# THE HONOLULU COUNTY MEDICAL LIBRARY

---

MRS. ETHEL HILL, *Librarian*

MISS KATHERINE NEWHALL, *Assistant Librarian*

PHONE 6-5370

8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.

Monday through Friday

Closed Saturdays at noon and Sundays

Closed all day and evening on National holidays  
and at noon on Territorial holidays.

---

## RECENT ACQUISITIONS

### Allergy

Segal, N. S. *The management of the patient with severe bronchial asthma*. c1950. (gift of publisher)

### Anatomy and Physiology

Berry, R. J. A. *Surface anatomy*. 1906. (gift of Dr. Wayson)

Bowditch, H. P. *An American textbook of physiology*. (gift of Dr. Wayson)

Bowditch, H. I. *The young stethoscopist*. 2nd ed. 1847. (gift of Dr. Wayson)

Lee, D. H. K. *The physiology of tissues and organs*. c1950. (gift of publisher)

Wilson, Sir Erasmus. *A system of human anatomy*. 1858. (gift of Dr. Wayson)

### Bacteriology

Fraenkel, Carl. *Mikrophotographischer atlas der bakterienkunde*. 1895. (gift of Bishop Museum)

Gay, F. P. *Agents of disease and host resistance*. c1935. (gift of Medical Group)

### Cancer

Liljencrantz, Eric, ed. *Cancer handbook of the Tumor Clinic, Stanford University School of Medicine*. c1939. (gift of Medical Group)

### Cardiology

Friedberg, C. K. *Diseases of the heart*. c1949. (gift of publisher)

Marvin, H. M. *You and your heart*. c1950. (gift of publisher)

### Chemistry

Bourget. *Manuel de chimie clinique*. 1891. (gift of Dr. Wayson)

College of Physicians and Surgeons, University of the State of New York. *Outlines of the lectures on chemistry*. 1828. (gift of Dr. Wayson)

Francis, C. A. *Fundamentals of chemistry and applications*. c1950. (from Nurses' Association)

Luck, J. M., ed. *Annual review of biochemistry*. v. 19. 1950.

### Dermatology

Besnier, Ernest. *Le musee de l'hopital Saint-Louis*. 1895. (gift of Dr. Wayson)

Duhring, L. A. *Cutaneous medicine*. Pt. I and II. c1895-97. (gift of Dr. Wayson)

Eichhoff, P. J. *Praktische kosmetik fur ärzte und gebildete laien*. 1902. (gift of Dr. Wayson)

Johnston, J. C. *Atlas of venereal and skin diseases*. 2nd ed. c1900. (gift of Dr. Wayson)

Morrow, P. A., ed. *A system of gentio-urinary diseases, syphilology, and dermatology*. 3v. 1893-94. (gift of Dr. Wayson)

Piffard, H. G. *A treatise on the materia medica and therapeutics of the skin*. c1881. (gift of Dr. Wayson)

Riehl, G. *Atlas of diseases of the skin*. Pt. 1-3. c1925. (gift of Dr. Wayson)

### Digestive System

Bockus, H. L., ed. *Postgraduate gastroenterology*. c1950. (gift of publisher)

### Gynecology and Obstetrics

Bandler, S. W. *Vaginal celiotomy*. c1911. (gift of Medical Group)

Barbour, A. H. F. *Gynecological diagnosis and pathology*. 3rd ed. 1922. (gift of Dr. Wayson)

Barbour, A. H. F. *Gynecological treatment*. 1922. (gift of Dr. Wayson)

Burns, John. *The principles of midwifery*. 2v. 1823. (gift of Dr. Wayson)

Engle, E. T., ed. *Menstruation and its disorders*. c1950. (gift of publisher)

Blech, Gustavus M. *The practitioner's guide to the diagnosis and treatment of diseases of women*. 1903. (gift of Dr. Wayson)

Moreau, F. J. *Traite pratique des accouchemens. Atlas de planches executees d'apres nature par Emile Beau*. 1837. (gift of Dr. Gaspar)

Thomas, T. G. *A practical treatise on the diseases of women*. 5th ed. rev. 1880. (gift of Medical Group)

Thoms, Herbert. *Training for childbirth*. c1950. (gift of publisher)

### Medicine

Baelz, E. *Lehrbuch der inneren medicin*. v.1-3. 1900-01. (gift of Bishop Museum)

Cutting, W. C., ed. *Annual review of medicine*. v1. 1950.

Foreman, Richard. *The Cherokee physician*. 3rd ed. 1857. (gift of Medical Group)

Marriott, H. L. *Water and salt depletion*. c1950. (gift of publisher)

Mekins, J. C. *The practise of medicine*. 5th ed. c1950. (gift of publisher)

## Neurology and Psychiatry

- Cushing, Harvey. *Papers relating to the pituitary body, hypothalamus and parasympathetic nervous system*. c1932. (gift of Medical Group)
- Fulton, J. F. *Physiology of the nervous system*. 3rd ed. rev. c1949. (gift of National Foundation of Infantile Paralysis)
- Harrower, M. R., ed. *Training in clinical psychology*. 1947. (gift of Josiah Macy, jr. Foundation)
- Haun, Paul. *Psychiatric sections in general hospitals*. c1950. (gift of publisher)
- Law, S. G. *Therapy through interview*. c1948. (gift of publisher)
- Livingston, W. K. *The clinical aspects of visceral neurology*. c1935. (gift of Medical Group)
- Sharpe, William. *Diagnosis and treatment of brain injuries*. c1920. (gift of Dr. Richert)

## Nursing

- Kalkman, M. E. *Introduction to psychiatric nursing*. c1950. (from Nurses' Association)
- Koos, E. L. *The sociology of the patient*. c1950. (from Nurses' Association)
- Seymer, L. R. *A general history of nursing*. 2nd ed. 1949. (from Nurses' Association)
- Spalding, E. K. *Professional nursing*. 4th ed. c1950. (from Nurses' Association)
- Williams, D. R. *Administration of schools of nursing*. c1950. (from Nurses' Association)

## Ophthalmology

- Atkinson, T. G. *Dynamic skiametry*. c1928. (gift of Dr. Van Poole)
- Crisp, W. H., ed. *Contributions to ophthalmic science*. c1926. (gift of Dr. Van Poole)
- Meller, Joseph. *Ausgewählte schnitten und reden*. c1935. (gift of Dr. Van Poole)
- Obrig, T. E. *Contact lenses*. c1942. (gift of Dr. Van Poole)
- Seltzer, A. P. *Diseases of the eye, ear, nose and throat*. c1950. (from Nurses' Association)
- Sluder, Greenfield. *Nasal neurology, headaches and eye disorders*. c1927. (gift of Dr. Van Poole)

## Orthopedics

- Bancroft, F. W., ed. *Surgical treatment of the nervous system*. c1946. (gift of National Foundation for Infantile Paralysis)
- Blount, W. P., ed. *American Academy of Orthopedic Surgeons. Instructional course lectures*, v.5-6. c1948-49.
- Holbrook, W. P. *Manual of rheumatic diseases*. c1950. (gift of publisher)

## Roentgenology

- Borden, W. C. *The use of the röntgen ray by the Medical Department of the U. S. Army in the War with Spain*. 1900. (gift of Dr. Wayson)
- Garratt, A. C. *Guide for using medical batteries*. 1866. (gift of Dr. Wayson)
- Sante, L. R. *Manual of roentgenological technique*. 9th ed. rev. c1942.

## Sex Education

- Greenberg, S. K. *Sex without fear*. c1950. (gift of publisher)
- London, L. S. *Sexual deviations*. c1950. (gift of publisher)

## Surgery

- Ellis, G. V. *Illustrations of dissections*. v.1 2nd ed. 1882. (gift of Dr. Wayson)
- Ellis, G. V. *Illustrations of dissections*. (atlas) 2nd ed. 1876. (gift of Dr. Wayson)
- Gardner, F. E. *Iconograms*. c1913. (gift of Dr. Wayson)
- Kelly, H. A. *The vermiform appendix*. c1905. (gift of Dr. Bell)
- Kirk, N. T. *Amputations*. c1942. (gift of Tripler General Hospital)
- Winter, Leo. *Operative oral surgery*. 2nd ed. c1943. (gift of Tripler General Hospital)

## Therapeutics

- Billig, H. E. *Mobilization of the human body*. c1949. (gift of National Foundation for Infantile Paralysis)
- Conn, H. F., ed. *Current therapy*, 1950. c1950. (gift of publisher)
- Ewerhardt, F. H. *Therapeutic exercise*. c1947. (gift of National Foundation for Infantile Paralysis)
- Fisher, A. G. T. *Treatment by manipulation*. 5th ed. 1948. (gift of National Foundation for Infantile Paralysis)
- Hawley, Gertrude. *The kinesiology of corrective exercise*. 2nd ed. rev. c1949. (gift of National Foundation for Infantile Paralysis)
- Kessler, H. H. *The principles and practices of rehabilitation*. c1950. (gift of National Foundation for Infantile Paralysis)
- Merck manual of diagnosis and therapy. 8th ed. c1950.
- Smith, O. F. G. *Rehabilitation, re-education and remedial exercises*. 1949. (gift of National Foundation for Infantile Paralysis)
- Tidy, N. M. *Massage and remedial exercises*. 8th ed. 1949. (gift of National Foundation for Infantile Paralysis)

## Miscellaneous

- American Hospital Association. *Cumulative index of hospital literature, 1945-49*. c1950.
- American Medical Association. *American medical directory, 1950*. 18th ed. c1950.
- Hare, H. A. *The national standard dispensatory*. c1905.
- Hirsch, August. *Handbuch der historisch-geographischen pathologie*. 3v. 1881-86. (gift of Bishop Museum)
- Quain, Richard, ed. *A dictionary of medicine*. 8th ed. 1884. (gift of Medical Group)
- Quarterly cumulative index medicus*. v.44. July-Dec. 1948. c1950.
- Shull, A. F. *Heredity*. 2nd ed. c1931. (gift of Medical Group)
- Simmons, J. S., ed. *Public health in the world today*. c1949. (gift of University of Hawaii)
- Stille, Alfred. *The national dispensatory*. 5th ed. 1896.

1 1 1

Dr. J. Robert Jacobson had a paper entitled "Psychodynamic modification of electric shock treatment" published in the *Psychiatric Quarterly* for April.

1 1 1

"Sulfone therapy in leprosy: a three year study" has been published in the Jan.-March issue of the *International Journal of Leprosy*. Drs. Norman R. Sloan, E. K. Chung-Hoon, N. E. Godfrey Horan and G. H. Hedgcock all contributed to this study.



## BOOK REVIEWS

*Sex without Fear.* By S. A. Lewin, M.D. and John Gilmore, Ph.D. 121 pp. Price \$3.00. Lear Publishers, Inc., Medical Division, New York, 1950.

This book is a valuable addition to the literature for two reasons: first, it is written in plain, simple language that anyone can understand; second, it is written in a concise outline manner. The already harassed bride or groom to be can obtain definite, well illustrated information along sound lines in a very short time. The biggest criticism of most of the better books on marriage relations is that they are long and windy, and perhaps better for perusal, at leisure, after marriage, unless the prospective couple prefers, as may be wiser, to spend a part of their premarital time in bookish pursuit rather than at Diamond Head.

The book can certainly be recommended to those who have put off their search for knowledge until the last minute.

C. C. MCCORRISTON, M.D.

*Psychiatric Sections in General Hospitals.* By Paul Haun, M.D., Med. Sc.D. 80 pp. An Architectural Record Book, F. W. Dodge Corporation, New York, 1950.

This little architectural brochure is concerned primarily with the relative merits of various designs for construction of psychiatric facilities in general hospitals, from toilets to treatment rooms. It will be of little interest to anyone not directly concerned with planning or construction.

It should, however, be required reading for all members of hospital boards, administrators and neuropsychiatric staff members who aspire to new or improved facilities for their patients in an overall hospital plan.

WILLIAM H. STEVENS, M.D.

*Light Therapy.* By Richard Kovacs, M. D. 112 pp. Price \$2.25. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

A very intelligent account of the most superficial portion of medical hocus-pocus.

S. F. STEWART, M. D.

*Textbook of Pediatrics.* Edited by Waldo E. Nelson, M. D., with the Collaboration of Sixty-Three Contributors. New, 5th Edition. 1658 pp. with 426 illustrations, 19 in color. Price \$12.50. W. B. Saunders Co., Philadelphia and London, 1950.

This 5th edition represents an improvement in what was already established as one of the best textbooks on pediatrics. Worthy of note are the new sections on parenteral fluid therapy, anesthesia, and inborn errors of metabolism, which are packed with essentials.

The section on infant feeding still contains a schedule for introduction of solid foods which would not be entirely accepted in many sections of the country. The section on physical growth and development and also that on mental and emotional development have not been changed significantly, but are well rounded.

This edition still rightly holds its place among the best of pediatrics textbooks.

DUKE CHO CHOY, M. D.

*The Physiology of Tissues and Organs.* By Douglas H. K. Lee, M.D., M.Sc., D.T.M., F.R.A.C.P. 172 pp. with 30 illustrations. Price \$4.00. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

This small volume presents a unique and interesting approach to physiology. It is divided into two sections. The first is a conventional handling of the functions of the various types of tissues. The second, and larger, portion has a brand new presentation. Instead of the customary system presentation, the author uses a functional approach. By means of this the author correlates the anatomy of different systems with somewhat similar functions as well as showing how all cells have basically similar functions with certain features being emphasized in each type.

It is ideally suited for its avowed purpose of instructing medical students in the fundamentals of physiology, and will provide anyone interested in the subject a brief, comprehensible review.

RAYMOND M. DEHAY, M. D.

*The Merck Manual of Diagnosis and Therapy.* Eighth Edition. 1592 pp. Price: Regular Edition \$4.50, Thumb-Index Edition \$5.00. Merck & Co., Rahway, New Jersey, 1950.

Obviously any book of 4 by 7 inches and less than 1600 pages which undertakes to present the etiology, diagnosis, symptoms, and treatment of all the diseases to which mankind is subject is taking on an impossible task. However, as a pocket book (large pocket) to serve as a guide to further investigation, the volume is well worthwhile. It is astonishingly up to date on newer discoveries, and the many tables make the presentation of large volumes of facts in a brief space possible and useful. Within its limitation of size it is excellent. I have ordered one for my own desk.

H. L. ARNOLD, M. D.

*Fundamentals of Chemistry and Applications.* By Charlotte A. Francis and Edna C. Morse. Third Edition, April, 1950. The Macmillan Company. Price, \$4.00.

The general plan and the content selection are much the same as recommended for a course in chemistry in the "Curriculum Guide for Schools of Nursing."

The authors of this elementary text are not unmindful of the titanic change in chemistry during the last decade and have kept in mind those students whose chemistry is directed toward obtaining a better understanding of physiology, microbiology, nutrition, and other phases of everyday living.

A discussion of radioactive elements has been given showing the value of these elements as therapeutic agents. Protective measures for safeguarding workers from exposure to radiation have been briefly touched upon. Many interesting diagrams are used. The text is simple and readable.

Miss Morse is a graduate nurse and because of this fact the reviewer of this text felt that much consideration had been given to the nursing student.

(MRS. WM. H.) ELIZABETH H. KOENIG, R.N.

*The Mask of Sanity.* By Hervey Cleckley, M. D. Second Edition. 569 pp. Price \$6.50. The C. V. Mosby Company, St. Louis, Mo., 1950.

The psychopathic personality is well presented and completely discussed in this book. Written simply and to the point, it is easy to read.

It is almost an entirely new book on this most interesting problem. He has written the book to follow the principles of science as formulated by Karl Pearson, which makes the contents well organized. As in the first edition, there is first a presentation of many case studies which demonstrate the psychopathic personality in all conceivable forms and all walks of life. Second, there follows a complete evaluation of this disorder, with comparisons made to the various psychoses, psychoneuroses and similar types of illnesses with which the psychopathic personality may be confused. The third part of the book deals with a descriptive clinical profile. Part Four is an attempt at the interpretation of what the psychopathic personality means, as well as a clarification of the many etiological factors believed to produce this type of disorder. In Part 4 Dr. Cleckley brings to a full conclusion how these personalities show almost a complete lack of understanding of life, or of feeling, in their relationships to other people.

Treatment is discussed to some degree. The difficulties involved with treatment—when so little is actually known about the disorder—are quite clearly explained.

There is a very well written appendix presenting the enormity of the problem in statistical form, with an excellent review of the literature. In this review Dr. Cleckley debates the conceptions and misconceptions presented by other psychiatrists.

The book is well worth the reading time of the general physician, especially the section concerned with comparison to other disorders and types of personalities. Psychiatrists will find it an aid in clarifying their thinking concerning the badly abused diagnostic category designated as psychopathic personality.

H. JOSEPH SIMON, M. D.

*The Management of The Patient with Severe Bronchial Asthma.* By Maurice S. Segal, M. D. 176 pp., with illustrations. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

In this book Dr. Segal presents a short summary of the treatment of severe bronchial asthma as we see it today. It appears that the treatments herein given are more directly applied to hospital practice than to practice as seen by the average physician in the home. Some of the methods of administering aerosol, etc. are somewhat impractical even for the best appointed office. The book falls short in that it does not offer much help to those of us who must treat patients afflicted with severe asthma not in the hospital but at home.

This book comes out too soon for the latest advances which have resulted from the treatment of asthma with ACTH and cortisone. The application of these latter two preparations to the treatment of asthma will, within the next few months, radically change the treatment of this condition.

An excellent review of the laboratory evaluation of therapeutic agents may be found in this book. It will do all practitioners of medicine a great deal of good to review these various studies, since one frequently tends to lose a broad viewpoint and concentrate on a few drugs. In studying this, one tends to broaden one's ability to use a variety of drugs.

F. L. GILES, M. D.

*Manual of Rheumatic Diseases.* By W. Paul Holbrook, M. D., and Donald F. Hill, M. D., with the assistance of Charles A. L. Stephens, Jr., M. D. 182 pp. with 119 figures and an index. The Year Book Publishers, Inc., Chicago, 1950.

This is a typical Year Book publication—compact, well illustrated, printed in large clear type, with a concise, logically arranged, readable and informative text. The index even includes references to the illustrations.

One chapter of 11 pages is devoted to cortisone and ACTH; and though it warns of their dangers, many details regarding the mode of administration of these drugs are given, and the general impression conveyed is that ACTH, at least, is indicated in the treatment of rheumatoid arthritis. This is at variance with the view of many workers, that these drugs are primarily of experimental value and that they will ultimately not be used therapeutically.

Another chapter, of 14 pages, is devoted to the "collagen diseases", polyarteritis nodosa, systemic lupus erythematosus, dermatomyositis and scleroderma. The frequent references to the great value of Benadryl, especially in lupus erythematosus, will be a source of practically no distress whatever to Parke, Davis & Co.

The final 55 pages of the book are devoted to the prevention and correction of arthritic deformities, with abundant illustrations. Details of exercise programs are given, and specific instructions for managing each of a wide variety of specific deformities.

The book is aimed right at the general practitioner and it should be extremely valuable to him.

HARRY L. ARNOLD, JR., M. D.

*Achieving Maturity.* By Jane Warters. First Edition. Price \$3.00. McGraw-Hill Book Company, New York, Toronto, London, 1949.

There has always existed a need for more significant, less technical means of counseling patients in the confusing period between childhood and adulthood. The family doctor is frequently consulted about emotional problems in adolescence, yet often there is a gap in his education and experience between pediatrics and the adult diseases.

This new volume, concerned chiefly with the developmental experiences of adolescence, should help to fill the gap. Physical, intellectual, emotional and social growth are concisely outlined with a maximum of wheat, a minimum of chaff. Amply fortified with recent and highly significant research studies, the approach is sufficiently frank to interest adolescents without alienating parents.

Written by an experienced counselor, the book is slanted directly toward the youthful reader in language both simple and readable. The physician would do well to recommend this volume to the next teen-ager who enters his office with one of the perplexing problems of adolescence. If none enters, he may need to read it himself.

WILLIAM H. STEVENS, M. D.

*Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death.* Sixth Revision of the International Lists of Diseases and Causes of Death. Volume 1 and Volume 2 (alphabetical index). Price \$6.00. Columbia University Press, New York, 1948.

This manual replaces the former International List of Causes of Death and is expanded to include in a single list, a statistical classification embracing morbidity as well as mortality with the emphasis on morbidity. One will therefore find items like "tinnitus," "excessive sweating" and "fallen arches," for example, which have nothing to do with causes of death.



The great value of this manual lies in its adoption by twenty-nine countries so that now statistical comparisons of morbid conditions between nations is permitted by the acceptance of a uniform system of classification.

The manual consists of two volumes: the first, published in 1948, contains the tabular lists arranged in numerical code order. The second volume, published in 1949, is an alphabetical index. The manual would be much handier for reference if these two volumes were combined in one.

Certain logical and much needed changes have been made. Typhus fever is divided into endemic, epidemic and Brill's disease, instead of being under one heading; influenzal meningitis, due to the influenza bacillus is no longer included under virus influenza; and Hodgkin's disease is removed from parasitic and infectious diseases, where it formerly nestled between "other venereal diseases" and "mumps."

"Neoplasm" is used instead of "cancer" and "immaturity" replaces "prematurity." Arteriolar nephritis and nephrosclerosis are no longer classified under "nephritis," but under "Hypertensive Disease." This will be reflected in a seeming drop in deaths ascribed to nephritis.

At last the attending physician can indicate the underlying cause of death, and can name tuberculosis, syphilis and leprosy together, indicating which, in his opinion, caused the death. This is accepted by the statistician. Formerly, syphilis always outranked tuberculosis, and leprosy outranked both, and the statistician—seldom a trained physician or pathologist—chose the cause of death from an arbitrary list of "Joint Cause Relationships."

Every physician should read pages 344 through 352 of Volume I on "Medical Certification and Rules for Classification" not once, but several times. It would do wonders in stopping the annoying but necessary habit that Vital Statistic Bureaus have of returning death certificates for completion with notes such as, "acute or chronic?", "site," "broncho or lobar?", "please state such and such" or even "what do you mean?"

JAMES R. ENRIGHT, M.D.

*A General History of Nursing.* By Lucy Ridgely Seymer, M.A., S.N.R. Second Edition. 39 Illustrations. The Macmillan Company, New York, 1949.

This book is definitely, as the title indicates, a general history of nursing. As the author has stated in her first preface, this book is an outline of nursing development to the present day. Her outline begins chronologically with the "Origins" and ends with the "Nurses' Organizations."

The wide historical scope of nursing has been successfully incorporated in a meager volume such as this. The pre-nursing history which may have influenced the evolution of nursing is included. The historical survey is chronologically presented which enables the reader to follow her admittedly sketchy sequence of events without becoming distracted.

Amazingly enough, this little volume takes in the Early Christian Periods to Reformation and Renaissance, then to the end of eighteenth century in the first four chapters. The remaining twelve chapters deal with the nineteenth century when nursing actually started taking root, simultaneously with the emancipation of women. Due credit, nonetheless, is given to the religious sisterhoods who were really the precursor of the non-sectarian leaders in the art of primarily spiritual but nursing care of the sick before the nineteenth century.

The vast historical scope of nursing has been adequately covered in a limited space. No field of nursing which has in any way contributed to its evolutionary progress has been omitted.

This book is essentially an epitome of the history of nursing, and as such, would benefit harassed teachers of this subject and researchers alike, in this field. Perhaps, even the students in training could benefit much from this book as a supplementary reading, especially towards the end of the course.

Finally, the exhaustive bibliography and the informative appendices in themselves are invaluable for busy instructors. This book is a "must" and should be found in every hospital library, and especially one with a school of nursing.

YETTA ISHIKI, R.N.

*Professional Nursing: Trends and Adjustments.* By Eugenia Kennedy Spalding. Fourth Edition, 1950. J. B. Lippincott Company.

This new fourth edition appears not only with a new title but also with an amplification of trends influencing nursing.

Treatment and analysis is given to such subjects as influences affecting nursing, the effects of recent developments, nursing in transition, the major questions and responsibilities for solving problems, criteria of a profession and the preparation for professional nursing.

Material concerned with the status of national nursing organizations, legislation and legal relationships, personal responsibilities, public relations and economic security reflects the vast changes in nursing within the past five years.

The writer of this review used this text as a reference in a recent class in Professional Adjustments II and found it most helpful and enjoyable. Copies should be found in an "up-to-date" school of nursing library.

(MRS. WM. H.) ELIZABETH H. KOENIG, R.N.

*Diseases of the Eye, Ear, Nose, and Throat. A Textbook for Nurses.* By Albert P. Seltzer. First Edition, 1950. McGraw-Hill Book Company, Inc. Price, \$4.00.

The text of this book has been prepared by one who has spent many years giving instructions to nurses on diseases of the eye, ear, nose and throat, and it is intended to assist not only the student, but also the teacher.

The author has written in such a style as to present a broad picture of the entire subject—basic general nursing study, both medical and surgical; a thorough foundation in the knowledge of the anatomy and physiology of the eye, ear, nose and throat; special methods of care and techniques of treatment. And throughout the book the nurse is constantly reminded of the growing importance of her part in caring for eye, ear, nose and throat patients.

It is simply and understandably written, with clear and interesting diagrams and invaluable bibliography. It is largely because the author has given such consideration to students of this specialized branch of nursing that this reviewer feels it is an excellent textbook for reference or for classroom use.

(MRS.) ISABEL M. MEDEIROS, R.N.

*Practice of Medicine.* By Jonathan Campbell Meakins, C.B.E., M.D., LL.D., D.Sc. Fifth Edition. 1,558 pp. with 518 illustrations. Price \$13.50. The C. V. Mosby Company, St. Louis, Mo., 1950.

In this large volume the author and several consulting authors attempt to cover the field of Internal Medicine. In some fields the presentation is admirable and in



others it is extremely brief. An attempt is made to compensate for this by a fairly good-sized bibliography. Unfortunately, well over half of the references are between twenty and thirty years old, making many of them of historical interest. Numerous important, recent references have been omitted.

A particularly commendable point is the space allotted to a discussion of the physiology of signs and symptoms at the beginning of each section. This will be valuable to the practicing physician not so recently out of school as well as the medical student.

The black and white figures are excellent and plentiful. About half of the colored pictures are poorly done and convey the author's idea with difficulty.

The section on electrocardiography is profusely illustrated. The illustrations are excellent for the three standard leads, but unfortunately only one precordial lead instead of the customary three was included, making the chapter a bit obsolete in this respect.

The consulting author who wrote the section of Diseases of the Central Nervous System has included some excellent diagrams and gives a very lucid anatomico-physiological discussion of his subject.

The new section on Psychosomatic Medicine gave promise of being very interesting. The writer gives a developmental picture of personality formation as visualized by the psychoanalysts. Unfortunately, the succeeding sixty-five pages were missing from the reviewer's copy and full evaluation of the chapter was impossible.

The newer antibiotics after penicillin and streptomycin are covered by a very short paragraph on aureomycin. The important use of aureomycin in the treatment of the rickettsial diseases is hinted at by two lines of small print. Chloromycetin was not mentioned. ACTH was not mentioned in connection with the treatment of rheumatoid arthritis.

This book clearly shows how large the field of Internal Medicine has become, and how one person can cover only certain fields well. It will prove particularly helpful in the field of differential diagnosis, if supplemented by recent literature, because of the large number of diseases discussed or mentioned.

RAYMOND M. DEHAY, M.D.

*Parkinson's Disease.* By Walter Buchler. 79 pp. Price \$1.00. Walter Buchler, 101 Leaside Crescent, London, N.W. 11, England, 1950.

This little book, written by a sufferer from Parkinson's disease, is a patient's story of his fight against the disease. Being gifted with unusual intelligence, insight and fortitude, the author has carried on his life in spite of severe handicaps. Here, set down, are innumerable simple aids and bits of advice to sufferers from this disease. It is worthwhile reading for doctors as an account of how the profession appears to a patient. In selected cases, it could be recommended to patients.

JOHN J. LOWREY, M.D.

*Current Therapy 1950—Latest Approved Methods of Treatment for the Practicing Physician.* Howard F. Conn, M.D., Editor. 736 pp. Price \$10.00. W. B. Saunders Co., Philadelphia and London, 1950.

In this day and age of such rapid advancement, particularly in therapeutic methods, books such as this are out of date before they are even contemplated. In places where there is an adequate clinical library, such as Honolulu, I do not believe that this book is indicated or should be bought by practicing physicians, because much more detail and adequate information can be obtained from the Index Medicus. However, in rural areas this might be a very valuable book. The treatment methods suggested are, on the whole, acceptable, and are given in concise and logical sequence.

J. L. BELL, M.D.

*Postgraduate Gastroenterology—As Presented in a Course Given Under the Sponsorship of The American College of Physicians in Philadelphia December 1948.* Edited by Henry L. Bockus, M.D. 670 pp. with 258 figures. Price \$10.00. W. B. Saunders Co., Philadelphia and London, 1950.

Undoubtedly, the best way to keep abreast of the rapid increase in our medical knowledge is to attend the various postgraduate medical courses given periodically throughout the year at all of the leading medical centers for physicians who are well familiar with the basic groundwork. The postgraduate courses sponsored by the various specialty groups, such as the American College of Physicians, are particularly helpful. The present volume is thoroughly readable, very informative and presents a very clear picture of the present day status in gastroenterology. It is in no sense didactic. The controversial issues are clearly set forth and recent trends in investigations are presented. Many very interesting and excellent case presentations occur throughout this volume.

While "Postgraduate Enterology" is particularly applicable to those interested in the field of gastroenterology, the subject matter is of sufficiently interesting reading so that the general surgeon, the gastric surgeon, and the general practitioner may well profit by many of the lectures contained in this volume. Some have maintained that books, such as this one, eliminate the necessity of attending postgraduate courses. I do not believe this is so. It is true that this book contains most of the discussions of the subject, including that brought up from the floor. However, every member who participates in this course usually has his own individual questions in which a few minutes of discussion will save many long hours of often fruitless reading. Furthermore, one always gains much from "off-the-record" discussions among the group which occur between various sessions that are held in these postgraduate courses.

In conclusion, I wish to say that I think this is one of the best books of the postgraduate series which has appeared in many years and I can highly recommend it to all.

L. CLAGETT BECK, M.D.

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 297th regular meeting of the Hawaii County Medical Society was held in the staff room of the Hilo Memorial Hospital on June 22, 1950. **Dr. K. K. Ota** was present as guest.

The colored sound motion pictures produced by Eli Lilly and Company on Kidney Function in Health and Kidney Function in Disease were shown to the members present.

The meeting was called to order by **Dr. Pete T. Okumoto** at 9:20 p.m. due to the absence of the regular president and vice president. **Dr. K. K. Ota**, who is doing locum tenens for **Dr. M. H. Chang**, was introduced to the society. The guest speakers for the July meeting were announced. Since a number of Society members were off the Big Island, a quorum was not obtained. Therefore, no business was conducted.

PETE T. OKUMOTO, M.D.  
*Secretary*

The 298th regular meeting of the Hawaii County Medical Society was called to order by the secretary, **Dr. Pete Okumoto**, in the absence of the president and the vice president, at 7:45 p.m. at Naniloa Hotel on July 5, 1950 with the following members present: **Drs. Bergin, Brown, Chock, Crawford, Hata, Jenkin, Kasamata, Kutsunai, Leslie, Loa, Matsumura, Miyamoto, Mizuire, Okumata, Ota, Phillips, Seymaur, Tamaguchi, R. Yamanaha, and Yuen.** **Drs. Gaenge and Ota**, who have made application for membership to the Society were also present. **Dr. Faus** of Honolulu was present as representative of the Hawaii Medical Service Association.

**Dr. H. Crawford** introduced the guests of the evening, **Dr. Louis P. River, Dr. Arkell M. Vaughn, Dr. Harry Peterson, and Dr. William Raim**, all of Chicago.

Letter dated July 5, 1950 from the Hawaii Heart Association addressed to **Dr. Pete Okumoto**, secretary of the Society, dealing with the coming heart clinic was read by the secretary protem. No action was taken.

**Dr. Crawford** reported that **Dr. A. Orenstein** was elected chairman of the Disaster Council at this afternoon's meeting. This body is composed of **Drs. Orenstein, Crawford, Wipperman, Seymour, and Carter.** The council is planning on coordination of an overall plan.

The chair informed the Society that the application of **Dr. Marian Leslie Hanlon**, a transfer member from Honolulu, and new applications of **Drs. Kay K. Ota and William G. Gaenge, Jr.**, will be placed on a month's waiting list as required by the by-laws. All three applications have been approved by the Board of Censors.

H.M.S.A.: **Dr. Faus** of Honolulu was next introduced by the chair. **Dr. Faus** reported that the HMSA is contemplating selling community insurance plan on an experimental basis in Hilo. Hilo was chosen because of its ideal size of population. The Association would like to cover both adults and families, especially those disqualified due to the fact that they do not come under the group plan. Large enrollment is necessary to counterbalance the bad risks that can enroll under this plan.

He requested the cooperation and help from the members of the Society by verbal advertisement in their offices and also interesting the various civic organizations to push the plan. Original idea was to sell the Hospital Coverage Plan only but the Association would like to sell the most workable plan to the public agreed upon by the members of the Hawaii County Medical Society. He asked for suggestions. Among answers to questions asked were: Tentative date of drive to be August 1 to 15, 1950; HMSA will send own representative from Honolulu; 70% enrollment is necessary for economical function of the plan; plan will have to go on even if the plan does not cover the outlying districts at present. **Dr. Phillips** reported that a group of physicians who met with Mr. Irwine thought that a combined Hospital and Surgical plan would be a suitable one for Hilo. The members at this meeting thought so too.

It was finally moved by **Dr. Phillips** and seconded by **Dr. Tamaguchi** that the chair appoint a committee of three to get together with Mr. Irwine to work out a combined hospital and surgical plan. This motion was unanimously passed. Appointed on the committee were **Drs. Crawford, Phillips, and Kasamata.**

**Dr. Arkell M. Vaughn** spoke on carcinomas of the stomach with lantern slide illustrations.

**Dr. Louis P. River** spoke on cancers of the breast, also with lantern slide demonstrations. He also showed a movie on the Self Examination of the Breast.

Both lectures were enthusiastically received.

Meeting adjourned at 10:13 p.m.

S. KASAMOTO, M.D.  
*Secretary Pro-tem.*

The 299th regular meeting of the Hawaii County Medical Society was called to order by the President, **Dr. Leo Bernstein**, at 8:30 p.m. at the Lanai on August 10, 1950. **Drs. Gilbert and Ota** of Hilo, and **Dr. Charles L. Wilbar** of Honolulu were present as guests. **Dr. Ira V. Hiscock**, Chairman of the Yale University Public Health Department, was the guest of the evening.

A letter dated July 17, 1950 from the Oahu Health Council, Inc., addressed to **Dr. Leo Bernstein**, President, on the possibility of extending membership to organizations on the islands other than Oahu, was read. The Council agreed unanimously that it would be most desirable to have the Hawaii County Medical Society as a member, but this will require an amendment to the By-laws. In the meantime, the chair requested an expression of opinion as to whether this society would care to join the Oahu Health Council in the event that this is made possible. **Dr. Leslie** moved that we join the Oahu Health Council if and when the Council amended its By-laws making it possible for the Hawaii County Medical Society to join. The motion was duly seconded and passed unanimously.

**Dr. Marian Leslie Hanlon**, a transfer applicant, and new applicants, **Drs. Kay K. Ota and William G. Gaenge, Jr.**, were unanimously elected into the society by secret vote.



The chair informed the society that the semi-annual meeting will be next month. With little coercion, the doctors of North Hilo, Hamakua and Kohala agreed to be hosts to the other members of the society. The time and place will be announced soon.

**Dr. M. L. Chang**, Treasurer, presented the sad financial status of the treasury to the members. He recommended that we look for new members or increase our dues. **Dr. Bergin** moved, seconded by **Dr. Leslie**, that the Constitution and By-laws under Funds and Expenses be amended to raise the annual dues by ten (10) dollars, from forty (40) to fifty (50) dollars. The motion carried.

Our president introduced **Dr. Charles L. Wilbar, Jr.**, President of the Territorial Board of Health, who in turn introduced the guest speaker, **Dr. Ira Hiscock**. **Dr. Hiscock** is here to carry out a health survey of the Territory. He had done two other surveys in 1929 and 1935. He is greatly pleased with the progress made in the Territory. He has reviewed evaluation schedules from two hundred or more districts from all over the United States and has found the evaluation schedules from the Territory of Hawaii among the best. He stated that the control and immunization of diphtheria in Hawaii is better than any other place in the United States. The maternal and child health situation has made tremendous improvements. Last year, 90 per cent of the mothers were delivered in hospitals on this island. This reduced the infant mortality rate very significantly. On the island of Hawaii, the tuberculosis death rate now is only 20 per cent that of 20 years ago. Although there have been improvements in the last 12 months, the records are not up to snuff in departments where the doctors have not participated in their control such as the sewage disposal, water supply and milk supply. **Dr. Hiscock** will, in the near future, make some major recommendations in his report. He has high praise for the Territorial and local health departments. In closing, he asked for suggestions to improve methods of approach and for the close cooperation of the local doctors in all health problems.

PETE T. OKUMOTO, M. D.  
*Secretary*

### HONOLULU COUNTY MEDICAL SOCIETY

The Society held its monthly meeting in the Mabel Smyth Auditorium on Friday, July 7, 1950 with 74 members and guests present. **Dr. Samuel L. Yee** presided.

A welcome was extended to the visiting mainland doctors who were present.

In accordance with the plan adopted at the March meeting, the following panel of doctors was approved for diagnosis, consultation and treatment of polio cases:

*Internal medicine*  
*General practice*

*Pediatrics*  
*Orthopedics*  
*Ear, Nose and Throat*  
*Eye*  
*Urology*

*Pathology*

**Dr. Morton E. Berk**  
**Dr. William M. Walsh**  
**Dr. Thomas Fujiwara**  
**Dr. John Peyton**  
**Dr. J. Warren White**  
**Dr. John Frazer**  
**Dr. Robert Wong**  
**Dr. R. O. Brown**  
**Dr. Edmund Ing**  
**Dr. Eric Fennel**  
**Dr. Sumner Price**  
**Dr. I. L. Tilden**  
**Dr. I. Kawasaki**

A colored movie entitled "Kidney Function in Health" was shown. The following papers were presented: "An Evaluation of the Present Problem of Carcinoma of the Cervix" by **Dr. Frank C. Spencer**, "Management of Idiopathic Epilepsy" by **Dr. Edward C. Wo Lum**, and "Treatment of Atomic Bomb Casualties" by **Dr. C. A. Domzalski**.

Refreshments were served on the lanai following the meeting.

The August meeting of the society was held in the Mabel Smith Auditorium with the President, **Dr. Samuel Yee**, presiding; about 96 members and guests were present. The following program was presented:

1. Colored movie—"Kidney in Disease" (Eli Lilly film)
2. "Evaluation of the Present Methods of Prostatectomy with Review of Cases of Transurethral Prostatectomy" by **Dr. A. J. Scholl** of Los Angeles (slides).
3. "Etiology, Diagnosis and Treatment of Rupture of the Bladder and Urethra" by **Dr. Vincent J. O'Connor**, Professor of Urology, Northwestern University (slides).
4. "Listener's Digest—Life at the AMA" by **Dr. A. S. Hartwell**, Delegate.

Members were urged to give blood to the Blood Bank for the Medical Society Reserve. The Board of Governors at its last meeting approved of doctors' families' participating in this pool.

**Dr. Dorothy Natsui** and **Dr. Ralph B. Cloward** were approved by the membership to serve as psychiatrist and neurologist, respectively, on the polio panel.

Refreshments were served in lanai following meeting.

WM. M. WALSH, M. D.  
*Secretary*

### KAUAI COUNTY MEDICAL SOCIETY

The monthly meeting of the Kauai County Medical Society was called to order by **Dr. Goodhue** at 7:30 p.m. on Wednesday, June 14, 1950 at Wilcox Memorial Hospital Library. **Dr. Warren White** was present as a guest.

A letter was read from the Hawaii Heart Association in regard to a diagnostic cardiac clinic to be held at Wilcox Hospital. The Society was advised that **Dr. John Bell** would be here on Wednesday, August 16, to conduct the clinic. He would see a maximum of ten patients both indigent and private from 10 to 12 a.m. and 1 to 2 p.m. Since no standard fee had been offered by the hospital at that time, the minimum cost to the patient could not be determined. It was moved by **Dr. Cockett**, seconded by **Dr. Kemp**, that the Society approve this clinic. All members present voted in favor of this. **Dr. Cockett** then made a motion that the members approve a ten dollar assessment for the purpose of decorating the banquet room at the AMA convention in San Francisco on Hawaii Night, these decorations to be chiefly floral. **Dr. Masunaga** offered to contact a florist and have the flowers flown to Honolulu. The motion was seconded by **Dr. Fujii** and the members voted their approval.

**Dr. White** then gave the members a preview of the paper he was to present at the AMA convention. His paper takes up the study of orthopedic defects due to the disease of leprosy. He presents a new slant to the study of this old disease. He feels that the peripheral necrosis of the extremities is due to capillary arteriolar vasospasm and suggests the possible use of sympathectomies. He is also interested in the value of orthopedic repair in the passive stages of the disease.



The monthly meeting of the Kauai County Medical Society was called to order by **Dr. Goodhue** at 7:30 p.m. on Wednesday, July 12, 1950, at Wilcox Memorial Hospital Library.

**Dr. Wollis** made a brief report on his investigation of the Honolulu Blood Bank Services. His report served to clear up some of the false impressions previously held. **Dr. Wollis** made a motion that Waimea and Wilcox Hospital operate independently on the Blood Bank situation. This motion was seconded by **Dr. Fujii** and unanimously approved. A letter from the Red Cross offering their planned Blood Bank service was read. It was voted on by the Society to defer action on this matter and to instruct them by means of a letter to this effect.

**Dr. Steuerman's** application for membership to the Society was read and it was moved by **Dr. Wollis**, seconded by **Dr. Kemp**, that he be accepted.

KEITH KUHLMAN, M. D.  
*Secretary*

### MAUI COUNTY MEDICAL SOCIETY

A regular dinner meeting of the Maui County Medical Society was held at the Maui Grand Hotel on June 20, 1950 at 6:15 p.m. with **Dr. Cole** presiding.

**Dr. Cole** mentioned about a letter from Mr. Dahlquist, president of Hawaii Heart Association, pertaining to the establishment of the proposed Heart Clinic at Puunene Hospital sometime in September 1950. In view of the Society's record of not approving such a program at the regular meeting on March 21, 1950, it has become necessary for the members present to reconsider the matter. A lengthy discussion followed. **Dr. Fleming**

moved, duly seconded by **Dr. Ohato**, that the Society approve the Heart Association program on Maui. Passed with one dissenting vote. **Dr. McArthur** moved, seconded by **Dr. H. Kushi**, that the Board of Governors be authorized to make recommendations to the Society at its next regular meeting regarding the feasibility and availability of the machinery of operation of the Heart Association program. Passed with five dissenting votes.

A letter dated May 31, 1950 addressed to Dr. Cole from **Dr. Molloy** of Molokai was read requesting for a change of status from regular membership to associate membership because of his plan to take residency training. In the short discussion that followed, Dr. Cole informed the members that there is no provision for associate membership in our Constitution and By-laws and heretofore, no precedent has been set by other society members under similar conditions. It was unanimously agreed that Dr. Molloy remain as a regular member of the Society as long as he desires to pay his dues and that no associate membership be granted.

**Dr. Haywood** reported on his recent trip to the Atomic Energy Commission. He stated the course began with orientation to the nuclear physics aspects of atomic energy followed by a conference on the unusual medical aspects of atomic warfare. He described the magnitude and destructiveness of atomic detonation and the resulting types of injuries, namely—blasts, burns and nuclear radiation. He concluded his report by mentioning briefly the various radioactive isotopes which are being used experimentally for diagnostic and therapeutic purposes in numerous blood diseases and neoplastic growths.

EDWARD T. SHIMOKAWA, M.D.  
*Secretary*

## Psychiatry

Nurse: What's wrong with that patient?

Doctor: Seems to have a split personality.

Nurse: And what did you recommend?

Doctor: Told him to go chase himself.



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 - 7-8411

# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## REPORT OF THE DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

I left on the evening of June 21 for San Francisco and spent the three days at the American Heart Association meeting. I was, however, appointed on a committee on arrangements for the post-convention American Medical Association Hawaii tour and, accordingly, arranged with the Hawaii Visitors Bureau to have several large posters advertising the tour delivered to Mrs. Bennett and myself in San Francisco.

On Saturday, June 24, Mrs. Bennett and I went to the managers of twelve of the largest San Francisco hotels and consulted them regarding these posters. In every case, the posters were displayed in a prominent place in the lobby of the hotels. In addition, both the airlines flying from San Francisco to Honolulu displayed these posters prominently and I took one of them out to the convention hall where more than 10,000 doctors saw it, as it was well displayed in the entrance. There has been some criticism of spending my time in this way but when we arrived in San Francisco, there were less than 100 persons planning to come on the tour and so far as I know, there are at least 300 coming as I write this on July 8.

On Sunday, June 25, I attended the annual Conference of Presidents and Other Officials of State Medical Societies. There Mr. Harry Becker of Detroit, Michigan, the Director of the Social Security Department of the United Automobile, Aircraft, and Agricultural Implement Workers of America, CIO, gave a talk entitled, "Labor Looks at the Problem of Prepaid Medical Care." He introduced his talk by saying that the subject of prepaid medical care should be and is a political debate. He thought that in a democracy such a problem as this which concerns so many people should be before the people to be voted upon. He stated the matters of the nation's health were constantly in Congress and that in the past two or three years, one senator in every five had signed at least one of ten medical bills. He felt that organized medicine and organized labor should understand each other but before this understanding could be complete, they would have to state each other's problems and see what could be done to settle them. He said that the issue was not whether prepaid medical care was going to come but rather whether it was going to be paid for by the Government or by voluntary insurance. He said that he felt the American Medical Association should be given credit for airing the debate widely.

He stated that at the present time, the CIO felt that the social security program should provide prepaid medical care through the Department of Public Health in the Federal Government. He then went on to say he felt physicians should re-analyze the prepaid medical care plans as they see them just as they would analyze a patient in trying to make a diagnosis. He stated that at the present time, labor has four possible doors open for prepaid medical insurance aside from the Federal Government's paying for it. First of all, they could take out insurance with private insurance companies; secondly,

they could use the Blue Shield and Blue Cross; thirdly, they could set up union clinics, that is, the unions themselves could employ doctors to care for their members; and fourthly, they could arrange with hospitals and individual doctors or clinics which are already in existence to care for their members. He stated that so far as he could tell, the American Medical Association states that either the Blue Shield or Blue Cross or private companies should be the method of prepayment.

He then spent some time analyzing these various factors. So far as the private insurance companies are concerned, he said that they in general give cash benefits only, which are inadequate; that they do not meet the standards which the CIO would agree to; and that there is in general no measure of the quality of medical care by these insurance companies. He stated that he was wondering whether the American Medical Association had made a deal with the commercial insurance companies in exchange for some funds to carry on their campaign against socialized medicine.

He went on to analyze in some degree the Blue Shield plan. He said it is at the present time new and is not satisfactory to labor because: (1) there is no real security provided by the Blue Shield; (2) it is in general limited to surgical diseases only; (3) there is not enough payment even for these; (4) it bears no relation to the charge by the doctor; and (5) in his opinion the income ceiling should be raised from \$2500 to \$5000 a year. It is too expensive, also. It is his claim that many of the Blue Shield plans have too high an overhead. The Blue Shield, as is true with the private insurance companies, does not attempt to improve the medical care. Also, prolonged illnesses are not covered. He said at the present time about 14,000,000 persons have enrolled in Blue Shield, Blue Cross plans, and that in some cases they did not get as much coverage as the private insurance gives.

He then went on to say that there were serious barriers between labor unions and the American Medical Association and that mistrust on the part of the unions towards the A. M. A. exists. There are several reasons for this mistrust: (1) one state medical society voted against the Blue Cross; (2) the type of publicity which the A. M. A. is engaged in, he thought was erroneously and poorly conceived; (3) the A. M. A. backs a book called *The Road Ahead*, which he says the CIO will never forgive the A. M. A. for circulating, as the CIO is in marked disagreement with the subject matter in it; (4) the A. M. A. is on record as being opposed to the Social Security plan to pay cash to those who have disability retirements. Mr. Becker then sat down.

He was followed on the rostrum by a very capable speaker, Mr. H. E. Flusher, of Jefferson City, Missouri, who was a member of the Board and Chairman of the Rural Health Committee of the American Farm Bureau Federation. He represented 1,490,000 farmer families in the United States who felt definitely that the A. M. A. and the farmers had a great deal in common, and he spoke very gratefully in favor of the program of the A. M. A.



He was followed by Mr. Baird H. Markham, Director of the American Petroleum Industries Committee of the American Petroleum Institute, who stated that it was his unequivocal opinion that free private enterprise, as it exists in the United States today, is the only reason for our economic and present prosperity. He glowingly praised the American Medical Association and doctors in general for what they had been able to accomplish and was wholeheartedly in support of their public relations program.

I give a report of this meeting in some detail because I think we all should have a clear understanding of the arguments which are being put out by those who favor socialized medicine.

Early on Monday morning, June 26, I went down to the Palace Hotel to register and there met a good many old friends whom I had seen in the previous three years as alternate delegate. The House of Delegates was called to order by the speaker, the roll call was heard. There were 196 delegates in all and 193 of them were present sometime during the next five days.

The first order of business was the selection of the recipient of the distinguished service award. This went to Dr. Evarts Graham of St. Louis, Missouri. The minutes of the interim session of December 6-9, 1949, were heard and approved. Next was the appointment of the Reference Committees which do the real work of the House of Delegates. Aside from the 13 regular Reference Committees, there was also appointed a committee on Emergency Medical Service and a committee for the Study of Veterans Affairs.

I was greatly surprised and pleased to be named a member of the Reference Committee on Insurance and Medical Service. The members of this committee were Dr. E. P. McNamee, Chairman, a radiologist from Cleveland, Ohio, and former President of the American Radiological Society; Dr. John S. Burton, from Oklahoma; Dr. McKeown of Oregon; and Dr. Warren L. Allee of Missouri. Throughout the rest of that day, resolutions were introduced to the House of Delegates and each one of these was referred to a different reference committee.

Of some 170 resolutions introduced, there were 4 *controversial issues*: (1) the appointment by certain hospitals of only Board men to fill their staffs. It was felt that general practitioners should be given a place on hospital staffs. (2) The care of veterans with non-service-connected disabilities. A resolution was introduced by a group of delegates from Tennessee headed by Dr. Harrison Shoulders to the effect that the Federal Government should pay the voluntary insurance premiums for veterans who might have non-service-connected disabilities. This was tabled. (3) The status of physicians (chiefly roentgenologists and pathologists) employed by hospitals (the Hess Report). This was adopted. (4) The New Jersey State Medical Association's plan for medical care, referred to the Committee on Insurance and Medical Care.

There were five matters referred to the committee of which I was a member: (1) A resolution introduced by Dr. L. H. Bauer, Chairman of the Board of Trustees, advocating prepayment plans for nursing service. This resolution was recommended by the committee and it was suggested that plans already in existence in certain areas be investigated in the consideration of this problem. (2) Dr. Bruce Underwood, of Kentucky, introduced a resolution to the effect that the American Medical Association should appoint a group of men to rate

private insurance policies, and approve or disapprove them, much as the Council of Pharmacy approves or disapproves drugs. There was a good deal of discussion on this resolution and Dr. Adson, of Minnesota, was most helpful. The resolution was not approved. It was felt that the state should rate the insurance companies engaging in business there. (3) Dr. Coventry, of Minnesota, introduced a resolution regarding the medical care of veterans and the committee approved this resolution. It was to the effect that service-connected disabilities be given every possible attention by all physicians. (4) We reviewed the report on the Council of Medical Service and the report of the Board of Trustees on the subject of the Commission on Chronic Illness. (5) The New Jersey State plan for medical care occupied the vast majority of the time of the Committee on Insurance and Medical Service, of which I was a member. The delegates from New Jersey, headed by Dr. James F. Norton, spent a great deal of time and energy in presenting their resolutions before the Committee. The plan was reviewed and opinions were heard, pro and con, for about four hours. There were twelve important points to the plan, several of which the Committee felt were so controversial that the plan could not at this time be approved. Dr. Norton was careful to point out that in New Jersey there were 5,400 practicing physicians, well over 90 per cent of whom had paid their regular dues and special assessments to the American Medical Association. The Committee worked all day Tuesday, June 27, on these matters, and, indeed, during the nation-wide broadcast by the A. M. A. of Dr. Henderson's speech, I was busy dictating the first draft of the reports of our deliberation to a secretary. At this time, I should like to state that Dr. E. P. McNamee, Chairman of the Committee that I was on, did an excellent job. He allowed the state of New Jersey much time to present their case and a good deal of time was spent afterwards in listening to arguments, pro and con. He arranged promptly to have meetings of the committee to see that business was expedited and the reports which were drawn up under his management were accepted, as written. In fact, the state of New Jersey was also very grateful in their acceptance of the decision of the committee and seconded the motion to have the resolution disapproved. It should be mentioned, however, that the speaker was empowered to appoint a committee to undertake further study of New Jersey's medical plan.

A special meeting of the House of Delegates was held at 9:00 A. M. on Wednesday, June 28, in order to consider action on resolutions which had been considered by the committee.

Thursday afternoon, June 29, at 1:00 P. M. the final meeting of the House of Delegates was held, at which time Dr. John W. Cline, a surgeon of San Francisco, California, was elected President-Elect; Dr. R. B. Robbins, of Arkansas, was elected Vice-President; Dr. George F. Lull, Secretary; Dr. J. J. Moore, Treasurer; and Dr. F. S. Borzell, Speaker of the House. Two new trustees were elected, Dr. L. W. Larson, of North Dakota, and Dr. Thomas Murdock, of Connecticut.

No description of the five days of work at this meeting would be complete without mentioning the entertainment provided for the House of Delegates. The first was a banquet given by the San Francisco County Medical Society for the House of Delegates on Monday, June 26, at the Palace Hotel. This was without a doubt one of the finest banquets I have ever attended. I sat at a table with Dr. Louis H. Buie, of Rochester, Minnesota, and



Mr. John Hunton, Executive Secretary of the California Medical Association. The banquet was notable for its excellent wine and following the dessert course, a talk by Dr. Salvatore Lucia describing the quality of the wine served at each course was enjoyed by all.

Many delegates enjoyed the hospitality of the California delegation which maintained a room where they served luncheon each noon. This hospitality was also evidenced by the state of Illinois which maintained a room at the Palace Hotel.

On Wednesday evening, a small banquet was held at the Clift Hotel. This was arranged by Dr. Julian Price of South Carolina who had the idea that states and territories who sent only one or two delegates to the A. M. A. might very well meet together and become better acquainted. This was certainly a delightful affair and I had a chance to meet other men from areas where there are smaller numbers of doctors, and we agreed to continue these meetings in the future.

On Thursday evening, there was a banquet given by the Woman's Auxiliary at which Hawaiian orchids and table decorations of flowers were beautifully arranged. Almost everyone was wearing an orchid lei or some other kind of Hawaiian lei, and Hawaiian music was played during the dinner. The flowers so impressed the several hundred guests that at the close of the dinner, table decorations were removed by guests who took the flowers to their homes.

On Friday, I was able to get out to see the exhibits and the commercial displays. So much of my time was required by the House of Delegates meeting that I was unable to attend the Scientific Session, and I have asked several physicians, including Dr. Orenstein, the Alternate Delegate, Dr. Morton Berk, Dr. Lyle Phillips, and Dr. I. L. Tilden to submit their impressions of the scientific papers.

At this time, I should like to thank Mrs. Bennett, your Executive Secretary, for her help, particularly in helping to arrange the post-convention tour to the Islands; Dr. Archie Orenstein who helped to entertain physicians from various parts of the United States who dropped into our rooms at the St. Francis Hotel; and Dr. F. J. Pinkerton, whose long experience in the House of Delegates has won him a host of friends and who was ready and willing at any time to give good advice to your new young delegate. It should be emphasized that he was active at the A. M. A. in seeing that his stand regarding the development of blood banks as an individual community responsibility, with the family and friends of each donor replacing doses of blood used, was most effective and was backed by the House of Delegates.

A. S. HARTWELL, M. D.  
*Delegate*

## General

**Patient:** Doctor, what I need is something to stir me up and put me in real fighting trim; did you get that in this R?

**Doctor:** Couldn't get *all* that in the prescription, but think you'll find it when you get the bill.



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 - 7-8411

# NOTES AND NEWS

## PERSONALS

**Dr. Harold Sexton** of The Clinic has been called to active duty as a Lieut. (jg), M.C., U.S.N.R. He is stationed at the Naval Dispensary.

The Queen's Hospital has secured the services of a new pathologist, **Dr. W. Harold Civin**, who will be an assistant to **Dr. Sumner Price**, Medical Director and Pathologist of the hospital. Dr. Civin comes to Honolulu after completing his training in pathology, including surgical and clinical pathology, at the Mayo Clinic, Rochester, Minnesota. His previous acquaintance with Hawaii came during his two years stay at Hickam Field during the war. Dr. Civin is a graduate of the University of Nebraska School of Medicine and interned at the Morrisania Hospital, New York City and also the Mount Sinai Hospital, New York. He has arrived with his wife and two children and will reside in Honolulu permanently.

The Territorial Board of Health has appointed **Dr. Claude V. Caver**, of Dallas, Texas as Medical Director of the Kalaupapa Settlement, to fill the vacancy caused by the resignation of **Dr. Norman Sloan**. Dr. Caver arrived in September to take up his duties at the Settlement after completing a period of graduate training in dermatology and syphilology at the University of Pennsylvania, Philadelphia, Pa. He also had considerable training in dermatology in Texas prior to going to Pennsylvania. Dr. Caver interned at The Queen's Hospital in 1945 and 1946 and also served in the U. S. Navy in the South Pacific.

**Dr. Richard D. Kepner** of Honolulu has announced the addition of **Dr. Kenneth H. Rusch** to his staff in psychiatry. Dr. Rusch is well known in Honolulu, having completed his internship and psychiatric residency at The Queen's Hospital.

**Dr. and Mrs. Fred K. Lam** of Honolulu have returned from a world tour, during which time they visited in Italy and other places on the Continent. They continued the trip around the world.

**Dr. Herbert T. Rothwell** of Kahuku has announced the association of **Dr. C. Reynolds MacKay** in the practice of medicine and surgery at the Kahuku Hospital and at a new office in Kaneohe. Dr. MacKay is a former interne of The Queen's Hospital and is a graduate of University of Utah School of Medicine, Salt Lake City.

A June wedding of considerable interest to island residents was the marriage of Miss Dorothy Greenwell, of the kamaaina Greenwell family on the Big Isle to **Dr. James E. Mitchell**, a recent interne of The Queen's Hospital. The wedding took place in Kona, following which the couple have gone to Baltimore, Maryland, where Dr. Mitchell will take postgraduate studies at Johns Hopkins University, where he graduated. The best man at the wedding was **Dr. William Frye**, also an interne at Queen's Hospital.

Another June wedding of much interest locally was that of **Dr. Eleanor Mayo Green** and **Dr. Henry Chauncey Akina**. Dr. Akina, a former member of the House of Representatives and a local eye, ear, nose and throat specialist, was married to Dr. Green in Westville, New

Jersey, and after a South American honeymoon they returned to Honolulu to open joint medical offices. Dr. Green is a native of New York and following her internship at The Queen's Hospital served as a resident in pediatrics at the Children's Hospital and also at the Leahi Hospital.

The Children's Hospital announces recent additions to their resident staff, which include **Dr. Roy Ohtani**, a native of Honolulu, who graduated from the Tulane University School of Medicine in 1947 and interned in New York City and Denver. Dr. Ohtani is the son of Mr. and Mrs. Ryukichi Ohtani. Another new resident is **Dr. John Anderson**, of Lafayette, Indiana, who was graduated from the Indiana University School of Medicine in 1949 and interned at the Seaside Memorial Hospital, Long Beach, California. **Dr. Masato Hasegawa** has been appointed chief resident, succeeding **Dr. L. T. Chun**.

The St. Francis Hospital has added to its resident staff **Dr. Y. K. Wang**, a native of Shanghai, China and a graduate of St. Johns University, Shanghai. He has served recently as a resident in obstetrics and gynecology at the University of Iowa Hospital, Iowa City, Iowa, and previously he trained at a number of hospitals in China.

**Dr. Lyle Bachman** has joined the Fronk Clinic, where he is specializing in obstetrics and gynecology. Dr. Bachman previously was associated with Drs. Batten and Bell.

The Kapiolani Maternity and Gynecological Hospital of Honolulu announces three new residents to their resident staff: **Dr. Charles M. Van Duyn**, of Wilmington, Illinois, graduate of University of Illinois in 1947, interned at the Illinois Research and Educational Hospital, following which he served a residency at the Augustana Hospital, in Chicago. He was in the Navy during 1949 as a Lt. (jg) in the Medical Corps. **Dr. Gustav Edward Rosenheim**, of Boise, Idaho, a graduate of the Jefferson Medical College, in Philadelphia in 1945, interned at the Swedish Hospital in Seattle, following which he served in the U. S. Army for several years. He was a resident in obstetrics at the Swedish Hospital in 1949-50 before coming to Honolulu. **Dr. Alexander Shevick**, a native of Indiana and a graduate of the University of Indiana School of Medicine in 1943, interned and served residencies in Chicago and Elgin, Illinois as well as at the Methodist Hospital, Gary, Indiana. He served two years as a Medical Officer in the United States Coast Guard.

Successfully completing the examinations for certification as a specialist in internal medicine by the American Board of Internal Medicine are the following Oahu physicians: **Dr. Morton E. Berk**, of the Medical Group, **Dr. John Bell**, of Honolulu and **Lt. Col. Doss Lynn**, assistant chief of medicine at the Tripler General Hospital, Honolulu. Congratulations!

**Dr. Donald S. Depp**, recently of Olaa, Hawaii, has opened his office for the general practice of medicine and surgery, in the Waikiki Medical Bldg., Honolulu. Dr. Depp was a plantation physician at Waipahu, Oahu; Koloa, Kauai and Olaa, Hawaii for a number of years following completion of a residency at the St. Francis Hospital, Honolulu, in 1941. He was graduated

from the University of Oregon Medical School in 1939 and interned at Sacramento City and County Hospital, Sacramento, California. Dr. Depp served in the United States Army Medical Corps for several years and was discharged in 1945.

An epidemic of births took place in families of the local medical profession during the summer: **Dr. and Mrs. Robert F. Bailey** became the parents of a second son, Robert Clifton, who was born in The Queen's Hospital, July 2nd. This is their 3rd child. **Dr. and Mrs. Dorian Paskowitz** announce the birth of their first child, daughter Claudia, born at the Kapiolani Hospital, July 1st. **Dr. and Mrs. William John Halmes** announce the birth of their 3rd child and 2nd son, William Ward, who was born at The Queen's Hospital, on July 24th. **Dr. and Mrs. Ogden D. Pinkerton** were likewise the parents of a son, Mark Purdy, born July 24th, at The Queen's Hospital. **Dr. and Mrs. James Marnie**, chief resident in surgery at The Queen's Hospital became the proud parents of their first child and son, Bruce James, August 30th. **Dr. and Mrs. Louis L. Buzaid**, radiologist, of The Queen's Hospital announce the arrival of a son, Francis James, born on July 28th. **Dr. and Mrs. Morton E. Berk** are the proud parents of a daughter Heather April, who was born at The Queen's Hospital, on July 31st and weighed 9 pounds 5 ounces.

**Dr. Paul D. White**, of Boston, the brother of **Dr. J. Warren White**, of Honolulu, who delivered a notable series of lectures in Honolulu this spring was signally honored by Harvard University, which granted him an honorary Doctor of Science degree at the annual commencement exercises.

**Dr. and Mrs. William Shanahan** vacationed at their home in Kahala, Honolulu during this summer prior to their departure to Galveston, Texas, where Dr. Shanahan will become Professor of Psychiatry at the University of Texas Medical School. Dr. Shanahan recently completed extensive postgraduate training in psychiatry as well as teaching psychiatry at the Northwestern University, Chicago, Illinois.

**Dr. Raymond T. Uyeno** of Honolulu celebrated with an open house the opening of his new office building, on Nuuanu Avenue, in August. He replaced the former building in this location with a modern two story construction. **Dr. Robert C. H. Lee**, ophthalmologist, has moved his office to the second floor of this new structure.

**Dr. William M. Walsh** of Honolulu has recently opened his office in the Alexander Young Bldg. for the practice of medicine and surgery. Previously he was associated with Drs. Batten and Bell, in the Dillingham Bldg.

**Dr. Kamehameha Lun-Lai Wong** has returned to Honolulu with his family from Staten Island, New York. Dr. Wong has joined the medical staff of the U. S. Public Health Service as an assistant surgeon. He is a native of Honolulu and received his M. D. degree from Peiping National Medical College and was a prisoner of war in Peiping. He has recently received an M. S. degree, from the Columbia University College of Physicians and Surgeons.

**Dr. W. Jahn Halmes** of Honolulu has returned from an extended trip to Europe. He presented papers on ophthalmology at meetings in Paris, London and Cairo. His plans for a trip around the world, including a visit to India, were interrupted by the onset of the war in Korea. Dr. Holmes has been elected to the American Ophthalmological Society.

Among the new internes at The Queen's Hospital are two local physicians: **Dr. George H. Mills**, son of Mrs. James Mattoon, began his internship after graduating from the Boston University Medical College. Dr. Mills is a graduate of Kamehameha School, Honolulu and studied at the Colorado State College before going to Boston. Dr. Mills is married and has a three-year-old son. Another local physician is **Dr. Robert Mookini**, son of Mr. and Mrs. R. K. Mookini, of Honolulu. He is a graduate of Tulane University Medical School, New Orleans, this year.

**Dr. Marcus Guensberg**, Medical Director, Territorial Hospital in Kaneohe, left on August 24 to attend the First International Congress of Psychiatry in September in Paris, France. In the early part of October, he will attend the Mental Hospital Institute in St. Louis, Mo., and visit various mental hospitals on the mainland. He will return to Hawaii on October 24.

## Hawaii

### Self-Improvers

**Dr. R. S. Fillmore** of Kohala left the islands during the last week of June for a one-year post-graduate study on the mainland. **Dr. Marion L. Hanlon** is handling his practice during his absence.

**Dr. Wilfred H. Kurashige** resigned his position at Hutchinson Sugar Company Plantation on July 31, 1950. He plans to study dermatology for three years at some eastern medical center, probably New York University Bellevue Medical School. Mrs. Kurashige and the two children will accompany Dr. Kurashige to the states. His duties as plantation doctor are taken over by **Dr. Gordon F. Liu** of Honolulu, who arrived at Naalehu with his wife on August 2, 1950.

### Relaxers

**Dr. and Mrs. E. B. Cunningham** and family of Pahala, Hawaii departed on a one-month vacation on the mainland, and returned to his vocation on August 1, 1950. **Dr. W. H. Kurashige** of Naalehu covered Pahala during the month.

**Dr. and Mrs. S. R. Brown** left Hilo on July 24, 1950, to vacation on the mainland. They will first visit their two children in the western states and then travel eastward. The Browns will be gone for three or four months. During his absence, his practice is continued by **Dr. F. I. Gilbert, Jr.**, of San Francisco. Mrs. Gilbert and their three children are here with him.

**Dr. and Mrs. Samuel M. Haraguchi** and family visited Honolulu for a short stay in the month of July.

### Returnees

**Drs. Leo Bernstein** and **T. D. Woo** are back at work—still daydreaming about their vacations.

### Visitors (for a change)

**Dr. Louis River** and **Arkell Vaughan**, both of Chicago, Ill., spoke to the society at the July 5th meeting. Both doctors were on their Post AMA Convention tour of the islands. Dr. River spoke on cancers of the breast and Dr. Vaughn spoke on carcinoma of the stomach.

**Dr. Robert B. Faus** of Honolulu visited the Orchid City on HMSA matters during July. He presented the HMSA Community Plan to the society members during



its July 5th meeting. This is the plan that the HMSA is offering to the people of Hilo during the period from August 1 to August 15.

### Maui

**Dr. Guy S. Hoywood** of Puunene returned recently from attending the Atomic Energy Commission on the mainland.

**Dr. Thomas Mar** of Hana is planning to leave for the mainland to take his pediatric board examination at San Francisco.

**Dr. James Fleming** of Wailuku will take over his practice during his absence.

**Dr. Joseph E. Molloy** of Maunaloa, Molokai, is planning to start his residency training at the All Saint's Hospital in Fort Worth, Texas on July 1, 1950.

**Dr. William Toney** of Lahaina is spending his three weeks vacation on Kauai. **Dr. Vernon K. Jim** of Wailuku is assisting **Dr. Edward T. Shimokawa** at the Pioneer Mill Co.'s dispensary and hospital.

## NEWS

### Honolulu Obstetrical and Gynecological Society

At a recent meeting the following new officers were elected: President, **Dr. Guy C. Milnor**; Vice President, **Dr. Lyle Bachman**; Secretary-Treasurer, **Dr. Rodney T. West**.

**Dr. Irving F. Stein**, Professor of Obstetrics and Gynecology, at the Northwestern University School of Medicine, Chicago, spoke on "Polycystic Ovaries and Sterility" at their meeting in August.

### Honolulu Surgical Society

A recent meeting of this Society included a talk by **Dr. Emil Goetsch**, Emeritus Professor of Surgery of the Long Island College of Medicine, New York, who spoke on "Modern Concepts in Surgery of the Thyroid."

At another meeting **Dr. Joseph T. Lucas** of Wahiawa presented a moving picture made in conjunction with **Dr. Kenneth Sawyer** of Denver, Colorado, on "Intrahepatic Cholangiojejunostomy." **Dr. Paul Gebauer** of Leahi Hospital spoke on "New Developments in Thoracic Surgery."

**Dr. Rogers Lee Hill, President**  
**Hawaii Territorial Medical Association**

Dear Dr. Hill:

The Board for the Licensing of Nurses felt that the physicians of the Hawaii Territorial Medical Association would be interested in knowing about the status of the Schools of Nursing in the Territory as compared with those on the mainland. The physicians of the Territory have all contributed a great deal to the education of these students and for this we are extremely grateful.

In the testing period from September 1949 through February 1950 in which 41 states including the Territory of Hawaii participated, the students from our 3 Schools of Nursing here ranked in the upper 8th. The placement ranged from 2nd from the top to 6th from the top as compared with all the other states.

We feel that this is indeed a tribute to the education these nurses have received with your assistance and would like to have you share in the pride we feel about this. We would greatly appreciate your thanking the doctors who participated in the teaching program of these nurses. Could we suggest that you openly thank them at your next regular monthly meeting?

From time to time we will be glad to keep you informed of the progress of our Schools of Nursing and trust you will continue to give your unqualified support to the education of these future nurses.

(Mrs.) **MABELCLAIRE NORMAN, R. N.**  
Executive Secretary

July 14

### The Hawaii Dietetics Association

On June 15, the members of the Hawaii Dietetics Association met at a luncheon dinner meeting at the Tripler General Hospital. Installation of officers for 1950-51 was held. Newly elected officers are: president, **Mary Lum**; president-elect, **Elsie Boatman**; secretary, **Ruth Toresen**; treasurer, **Virginia Cooksey**. Outgoing officers are: president, **Lorene Kulas**; president-elect, **Mary Lum**; secretary, **Ruth Toresen**; treasurer, **Elsie Boatman**.

Some of the outstanding projects of the year were summarized at his meeting. The revision of a low-salt diet was completed and was ready for publication. This diet utilizes the local products and can be easily adjusted to various food habits. The Association also participated in the Spring Home Economics convention at the University of Hawaii. Pamphlets on the demand of dietitians were distributed.

A series of articles featuring dietitians in the various fields of work in Hawaii was printed in the *Honolulu Star-Bulletin*. A complete description of the work and opportunities was presented by various dietitians. This was used as a means of recruitment.

### Surgeons' Meeting

The International College of Surgeons, United States Chapter, will hold its fifteenth Annual Assembly and Convocation in Cleveland, Ohio, October 31, November 1, 2, 3, 1950, according to George M. Curtis, M. D., Columbus, Ohio, Chairman of the Assembly.

All doctors of medicine interested in surgery and its advancement are invited to attend, and can obtain a program upon request to Arnold S. Jackson, M. D., Secretary, Jackson Clinic, Madison 4, Wisconsin. For hotel reservations, contact Committee on Hotels, International College of Surgeons, U. S. Chapter, 511 Terminal Bldg., Cleveland 13, Ohio.

### American College of Surgeons

Color television of surgical procedures from Massachusetts General Hospital to an auditorium in Mechanics Hall is one of the features planned for the thirty-sixth Clinical Congress of the American College of Surgeons which will be held in Boston from October 23 to 27, according to an announcement by Dr. Paul R. Hawley, Director. Twenty-four hospitals in Boston and vicinity will hold operative clinics for the visiting surgeons during the week. Official meetings, scientific sessions, medical motion pictures, a large technical exhibit, and the twenty-ninth annual Hospital Standardization Conference are among the other features of the extensive program, which is expected to attract around 5000 surgeons and hospital representatives from the United States, Canada, and other countries. Hotel headquarters will be at The Statler and Copley Plaza.

### Arthritis Research Fellowships

The Arthritis and Rheumatism Foundation is offering fellowships for research in the basic sciences related to the study of arthritis. These fellowships carry a stipend of from \$4,000 to \$6,000, depending upon the needs and ability of the worker, and run for a period of one year. The fellowships would begin in July 1951, although earlier appointments would be considered by the committee.

The Foundation is anxious to back a candidate, rather than a project, an institution, or a hospital. It hopes to arouse interest in arthritis in a wider circle of medical investigators and to encourage able, inquiring minds.

291601

Applications should be sent to the Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, New York, by January 1, 1951. Notification of the fellowships granted will be made March 1, 1951.

If any applications are received by September 15, 1950, they will be acted on at that time and notification made immediately.

#### **Tenth International Congress of Dermatology**

The Tenth International Congress of Dermatology will be held in London during the summer of 1952, under the presidency of Sir Archibald Gray.

A preliminary program will be prepared during the current year. All those interested are asked to communicate with me at the Institute of Dermatology, St. John's Hospital for Diseases of the Skin, Lisle Street, Leicester Square, London, W.C. 2.

GORDON B. MITCHELL-HEGGS, M.D.  
*General Secretary*

#### **American Public Health Association**

The 78th Annual Meeting of the American Public Health Association and meetings of 32 related organizations in the field of public health and preventive medicine will be held in Kiel Auditorium, St. Louis, Missouri, October 30 to November 3.

More than 400 speakers and discussants will participate in the scientific programs under development by the thirteen Sections. The Sections are: Dental Health, Engineering, Epidemiology, Food and Nutrition, Health Officers, Industrial Hygiene, Laboratory, Maternal and Child Health, Medical Care, Public Health Education, Public Health Nursing, School Health and Statistics.

The program for the St. Louis meeting will be published in the September issue of the American Journal of Public Health. Additional information may be obtained from Dr. Reginald M. Atwater, Executive Secretary, American Public Health Association, 1790 Broadway, New York 19, N. Y.

#### **American Urological Association Award**

**Urology Award**—The American Urological Association offers an annual award of \$1000.00 (first prize of \$500.00, second prize \$300.00 and third prize \$200.00) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Palmer House, Chicago, Illinois, May 21-24, 1951.

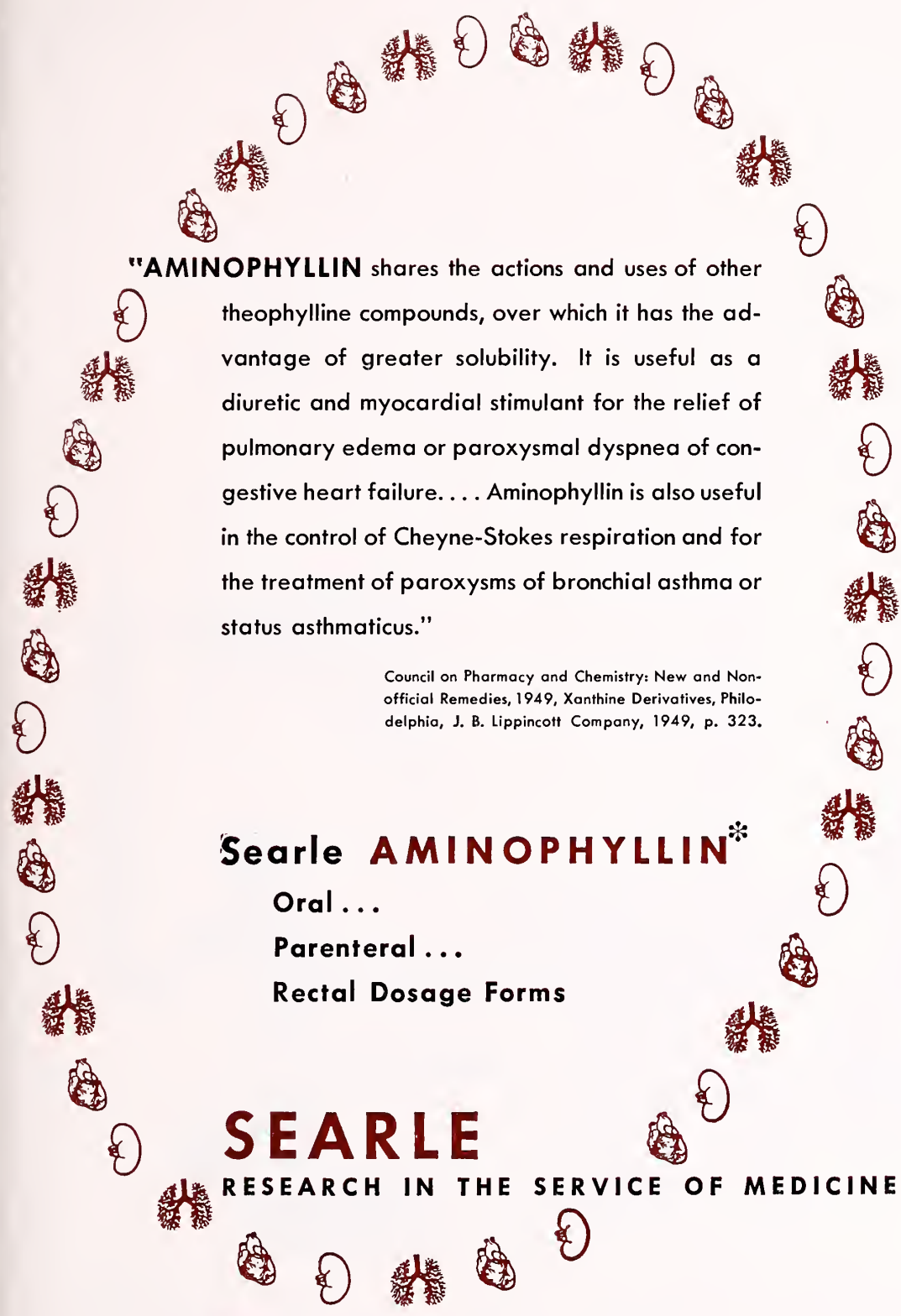
For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before February 10, 1951.

#### **Jobs with Uncle Sugar**

Medical Officer positions in the Federal Service paying \$5400, \$6400, and \$7600 per year will be filled from an examination recently announced by the Director, Eighth U. S. Civil Service Region, Saint Paul, Minnesota. Positions paying the above cited salaries are now vacant and there is an immediate need to fill these positions. Medical doctors who had just completed their internship are eligible for the positions paying \$5400. Medical doctors with one or two years experience performing responsible medical doctor duties are eligible for the positions paying \$6400 and \$7600 per year respectively.

Applications for these positions will be accepted until further notice. Application forms may be obtained at any first- or second-class post office. A copy of the examination announcement may be obtained by writing the Director, Eighth U. S. Civil Service Region, Saint Paul Post Office and Customhouse Building, Saint Paul 1, Minnesota.

Doctor's fully equipped office to sub-let in air-conditioned Waikiki Medical Building. Short or long lease. Reasonable rent. Call 6105.



**"AMINOPHYLLIN** shares the actions and uses of other theophylline compounds, over which it has the advantage of greater solubility. It is useful as a diuretic and myocardial stimulant for the relief of pulmonary edema or paroxysmal dyspnea of congestive heart failure. . . . Aminophyllin is also useful in the control of Cheyne-Stokes respiration and for the treatment of paroxysms of bronchial asthma or status asthmaticus."

Council on Pharmacy and Chemistry: New and Non-official Remedies, 1949, Xanthine Derivatives, Philadelphia, J. B. Lippincott Company, 1949, p. 323.

## Searle **AMINOPHYLLIN**\*

Oral . . .

Parenteral . . .

Rectal Dosage Forms

# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE



\* Contains at least 80% of anhydrous theophylline.



## To the Medical Profession:

We are exclusive  
agents in Hawaii for:

WYETH, INCORPORATED  
LEDERLE LABORATORIES, DIV.  
MALLINCKRODT CHEMICAL WORKS  
DAVOL RUBBER COMPANY

Our Drug Department is  
distributor for the following lines:

ABBOTT LABORATORIES  
BECTON-DICKINSON  
JOHNSON & JOHNSON  
WINTHROP-STEARNs  
ETHICON SUTURE LABORATORIES  
PARKE, DAVIS & COMPANY  
E. R. SQUIBB & SONS  
THE UPJOHN COMPANY  
HOFFMANN-LA ROCHE, INC.  
ORGANON, INC.



---

**AMERICAN FACTORS, LTD.** **AMFAC** Phone 5-1511

Drug Dept. — Extensions: Manager, 238; Order Desk, 226, 238; Warehouse, 236, 319

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

---

## BULLETIN COMMITTEE

VIOLET BUCHANAN, *Editor*, Leahi Hospital, Honolulu  
ALISON MCBRIDE, *Territorial Association Secretary*, Honolulu  
MYRTLE SCHATTEBURG, *Chairman, Nursing Information Committee*, Honolulu  
MABELCLAIRE NORMAN, *Executive Secretary*, Honolulu

### *Secretaries*

BESS HAMMER, Hawaii  
VIRGINIA RAUTENBERG, Honolulu  
PAULINE JOHNSON, Kauai  
LAURA WONG, Maui

### *Publicity Chairmen*

GRACE LUSBY, Hawaii  
HELEN GAGE, Kauai  
EILEEN MACHENRY, Maui

---

## EXECUTIVE SECRETARY'S MESSAGE

Five times across the Pacific in eleven months is really too often, even though I like to travel by air!

Just one year ago on Aug. 14, 1949 I came to Hawaii to serve as your executive secretary and I shall never forget that eventful day and the warm reception I received. Much has happened in this last year; much has been accomplished but there is still much to be done.

The first project was to establish a Counseling and Placement Service. This was accomplished in a comparatively short period of time. It has grown and grown and is now, as you all know, a part of the American Nurses' Association Professional Counseling and Placement Program. As of this date, some 86 nurses in the Territory have had their credentials compiled and nurses have been placed on the mainland, Guam and in Iceland as well as in the Territory.

Still another project was the Economic Security Program. This project has been getting under way till now at our recent convention, the whole thing has become an even closer reality. But we are not through yet, and will continue to need the assistance of every nurse who has any interest in her own security, in the future, and in the progress of her professional organization.

In May twenty of us went to the Biennial in San Francisco. This, too, can be marked down as an accomplishment for the organization. Everyone who went came back laden with ideas and plans for the future.

In July I had the good fortune to go to the Conference of Executive Secretaries in Chicago held by ANA. There were executive or elected secretaries from 46 states, the District of Columbia,

Puerto Rico and Hawaii. ANA paid my transportation, and your organization my living expenses while there. To me, the conference was one of the most valuable meetings I have ever been privileged to attend. Mutual problems were discussed and ways of solving them; new ideas and suggestions for the growth of our organization were brought out; and individual contacts with other executive secretaries resulted in a most stimulating meeting. A meeting of Counselors and Registrars followed. Here again, much valuable information was obtained. Once this material is compiled and presented to the Board of Directors and to those attending the Territorial Convention, you, too, will begin to reap the harvest of this trip to Chicago.

All this, and every other activity that has taken place this year, adds up to the fact that our Nurses' Association is now definitely well established and broadening our scope of activities and participating along with other associations on a national level. We have made ourselves known to others on the mainland and they are looking to us now as never before as a part of their professional groups. In itself, this fact presents a challenge to each and every member to contribute every bit she can—big or little. In this way, you will assist in strengthening your profession and the things for which it stands.

These things cannot be done by one person alone. As your executive secretary I can only do as much as you want me to do, and even that much, only with your assistance. You have all helped a great deal this past year, but this next year we will need more help, more cooperation and more coordination in order for nurses to accept its vital role in this changing world. "Sell" your organiza-

tion to those who do not belong. Remember, "In Unity There Is Strength," and working together we can make nurses and the nursing profession better all the time.

I have very much enjoyed this year as your executive secretary and with your continued help, look forward to a gerater year than ever before for the Nurses' Association, Territory of Hawaii.

MRS. MABELCLAIRE NORMAN, R. N.

### HAWAII STUDENTS RANK HIGH IN STATE BOARDS

The Board for the Licensing of Nurses feels that the nurses of the Territory would be interested in knowing about the status of the schools of nursing here in the Territory. As you all know, we have three fully approved schools—Kuakini, St. Francis, and Queen's. We have participated in the national state board test pool since 1946. A report now comes to the Board based on returns from 41 states and territories which participated in this examination between the periods of Sept. 1949 and Feb. 1950. This shows that the students from our three schools of nursing rank in the upper one-eighth. The placement ranged from second place from the top to sixth place from the top as compared with all the other states.

The Board feels that this is indeed a tribute to the education these nurses have received and wants you to share in their pride.

### LOCAL NURSE APPOINTED TO ANA COMMITTEE

It isn't often that the Nurses' Association, Territory of Hawaii is fortunate enough to have one of its members appointed to an American Nurses' Association Committee. This year we have received word that Mrs. Arlene Thompson, Director of Nurses at Children's Hospital, Honolulu, has been appointed to the ANA Committee on Florence Nightingale International Foundation.

This Foundation was first established in 1920 by the Red Cross as a public health nursing course given at Bedford College, London. A course in teaching and administration was added and the name Florence Nightingale International Foundation given at that time. Nurses from every country may be selected to be recipients of a scholarship from this fund.

The duties of the committee are (1) to formulate and recommend to the Board of Directors of ANA, the method of collection of funds for the Foundation. (2) To receive and evaluate and approve for scholarship and to make decisions regarding the awards of same; further, the committee is to approve applications of other American

nurses wishing to study under the auspices of the Florence Nightingale Foundation. (3) To recommend to the Board of Directors of ANA the amount of fund to be allotted each year to the Foundation or for scholarships from the funds which have been collected by the committee. (4) To develop promotional campaign.

We are very happy to congratulate Mrs. Thompson on this appointment and feel sure she will be a valuable member of the committee.

### NURSES RECRUITED FOR DISASTER PROGRAM

Past emergencies have proved the important part the nurses of a community play in time of disaster and need. As part of the Civilian Defense Program, now well under way, the Nurses' Association, Territory of Hawaii is calling on all nurses—active and inactive—to again organize themselves as they did during the last war when first aid stations went into full operation the moment a national emergency was found to exist.

Recently all licensed nurses in the territory were sent a questionnaire regarding their availability. When these cards were returned, they were segregated as to islands and each island then worked out its own program. Now that the program is definitely under way, the continued support of all nurses is requested. If you know of any nurses who have not received a questionnaire, have them contact their district association and enlist everyone for a possible emergency. As you all know, preparedness is the only insurance Civilian Defense has that makes it possible to function satisfactorily when a need arises. *Once a nurse, always a nurse.*

### RED CROSS COURSES TO BE GIVEN

The Hawaii chapter of the American Red Cross are making extensive plans to assist in the disaster program by offering courses in first aid and also in home care of the sick and injured.

The courses to be given on the island of Oahu are already planned and first aid courses are in progress. The courses on home care of the sick and injured will be given to lay people but qualified nurses are urged to enroll in the instructor's course for home care of the sick and injured. They may do so by contacting the local Red Cross.

Red Cross units on each of the islands are planning their own programs and it is urged that all possible enroll in one of these courses. We all need a little refreshing on first aid from time to time and certainly there are many nurses who could qualify to teach home care of the sick and injured. Get behind the disaster program!



## HOW TO BECOME ENROLLED IN THE AMERICAN NATIONAL RED CROSS NURSING SERVICE

Nurses enrolled under the old plan will retain their Red Cross badges and will continue to be known as Red Cross nurses unless they have lost their professional standing or resign voluntarily. Henceforth, nurses may qualify as Red Cross nurses by meeting the basic qualifications outlined below, plus the special requirements for a particular program or service.

### *Basic Qualifications:*

1. Registration in some state following graduation from a state-accredited school of nursing.
2. Current registration where it is required by law for the type of work the nurse is doing for the American Red Cross.
3. Satisfactory personal, educational, and professional qualifications, and state of health consistent with the function she plans to carry.
4. Participation in the regular volunteer orientation course when it is made available by the local chapter.

### *Special Service Requirements:*

1. As a home nursing instructor.
2. As an instructor of volunteer nurse's aides.
3. As a disaster nurse.
4. As a nurse in the National Blood Program.
5. As a committee member.
6. As a staff member.
7. As a nurse leader actively participating in Red Cross work.
8. As a volunteer Red Cross nurse giving supplementary community health service when such service is requested from the chapter. Services may include serving in a first aid station at fairs, parades, etc.; assisting health departments in special projects; assisting at special clinics.

Nurses may participate in Red Cross programs or activities other than nursing if they prefer and thereby earn their enrollment as suggested below. Nurses will be expected to meet the minimum requirements for whichever service they may elect, i. e., those participating in teaching services would take the necessary instructor training courses, and those participating in activities not involving teaching would take the orientation courses prescribed. If no special course is provided, at least six months service should be required as a qualification for enrollment.

1. Instructor of classes in First Aid.
2. Instructor in Water Safety.
3. Assisting with fund campaign.
4. Volunteer Services.

For more detailed information, contact Miss Loretta Schuler, Director of Nursing Service, Hawaii Chapter, American Red Cross, Honolulu, T. H.

## KEEPING UP WITH MEDICINE:

### Some Interesting Highlights from AMA Convention in San Francisco June 1950

Many health officers, epidemiologists, and medical men in general believe that the long established x-ray screening projects, which are at the present time getting miniature x-rays on 15,000,000 people yearly throughout the country, could be expanded to include other fields of medicine such as congenital and chronic heart disease, cancer of the lung, the metabolic diseases, including diabetes and syphilis. The technic would consist of simple tests for all these done at the same time as the miniature x-ray, by technicians circulating with the mobile x-ray units. (Symposium on Screening Techniques for the Discovery of Chronic Diseases in the Adult Population. Section on Preventive and Industrial Medicine and Public Health.)

### Cortisone and ACTH:

These two substances are effective in relieving the signs and symptoms of acute rheumatic fever and rheumatoid arthritis, as well as rheumatic heart disease. They are also valuable in a wide variety of other medical conditions, such as systemic (disseminated) lupus erythematosus, Addison's disease, asthma, uveitis, sympathetic ophthalmia, arthritis associated with psoriasis, allergic diseases, and so on. Both ACTH and cortisone are hormones, the first of which is secreted by the pituitary and stimulates the production of cortisone by the adrenal cortex. In the conditions mentioned, discontinuance of therapy usually results in recurrence of the old symptoms, so that the attitude at present is that one or both substances will have to be used like insulin as replacement therapy. (Symposium on ACTH and Cortisone. Section on Experimental Medicine and Therapeutics.)

### Antimicrobial Treatment in Tuberculosis:

Streptomycin and dihydrostreptomycin remain the most effective, best tolerated and most thoroughly tested in the treatment of tuberculosis; at the present time, they are used interchangeably and are equally effective. The doses in use are one gram two or three times a week. This produces a minimum of toxic reactions but still produces resistance in a high percentage of cases after prolonged treatment.

PAS (para-amino-salicylic acid) is the next most useful drug in the treatment of tuberculosis and is now being used almost exclusively in association with either streptomycin or dihydrostreptomycin. When the two are used together, there is less tendency for the production of resistant organ-

isms and the therapeutic effect is definitely enhanced. The dosage of PAS is 12 to 15 grams daily in divided doses.

Tibione or conteben is the new German drug discovered by Domagk, the discoverer of the sulfone drugs. Initial treatment with this drug, both in Germany and in this country, produced severe symptoms of toxicity, including liver damage, anemia and agranulocytosis, but it has now been discovered that the dosage was too high and a safe dose is about 100 mg. per day. This is tolerated well and when symptoms of toxicity appear, discontinuance of the drug is always necessary to restore the patient to normal. The efficacy of tibione in the treatment of tuberculosis is distinctly inferior to either streptomycin or PAS. Its most remarkable effect is on the sputum output which is radically reduced.

Neomycin has been disappointing clinically. A number of patients have already been treated with it and it has been found to be highly toxic for the eighth nerve, producing deafness in a high percentage of patients treated. At the present time no large scale therapy with this drug is being attempted because of its high toxicity.

Viomycin is much less toxic than neomycin and has about one-fifth to one-tenth the potency of streptomycin when used on clinical cases. Although it shows greater promise than neomycin, five patients treated with it have shown complete disturbance of electrolyte balance and in one patient, tetany. It is not recommended at the present time for clinical use.

Terramycin's efficacy in the treatment of tuberculosis is one-tenth to one-twentieth that of streptomycin. This substance is now commercially available but its effect on tuberculosis has not been impressive.

In summary, the most reliable system of treatment for tuberculosis in use at the present time consists of streptomycin in one gram doses given every two to three days in conjunction with PAS 12 grams daily. (H. Corwin Hinshaw, Report to American College of Chest Physicians, June 1950.)

#### Scientific Exhibits:

*Hansen's Disease: Orthopedic Manifestations and Treatment.* (J. Warren White, Lt. Jack W. Millar, U. S. N. and R. S. Dodge, Honolulu.)

This was a very interesting exhibit of the effect of leprosy on bones, including the deformities as shown by x-rays and the results of treatment with the sulfone drugs.

*The Flicker Photometer.* (A. C. Ivy and L. R.

Krasno, University of Illinois College of Medicine, Chicago.)

This is a very interesting and promising device which produces a flickering slit of light which a normal person can visualize both before and after a dose of nitroglycerine, but a person with early hypertension no longer is able to detect the flicker after a dose of nitroglycerine.

*Automatic Encephalographic Control of Anesthesia.* (R. G. Bickford, Albert Faulconer, Jr., D. E. Soltero and C. W. May, Mayo Clinic.)

This is a new and remarkable method for the automatic control of anesthesia in animals and man. Two electrodes are placed on the skull of the patient and attached to a small encephalograph. This, through a second circuit injects ether in accordance with the height of the brain waves of the patient. Both ether and sodium pentothal can be used in this way and cats have been kept asleep by this method, and in a steady state of surgical anesthesia up to forty-eight hours without subsequent complications. It has also been successfully used in the automatic control of ether anesthesia in man.

#### POLIO NURSING CARE INSTITUTE HIGHLY SUCCESSFUL

A great deal of credit is due Miss Loretta Schuler, Director of Nursing Service, Hawaii Chapter, American Red Cross and her Nursing Service Committee members, Mrs. Anice Olson, Mrs. Arlene Thompson and Mrs. Elaine P. Johnson for the fine institute on poliomyelitis nursing made available to graduate nurses in weekly classes from June 20 to July 20, 1950. Also helpful in planning and carrying out the program were Miss Mildred Asato, Clinical Arts Instructor, The Queen's Hospital School of Nursing and Miss Paula Sorg, Physical Therapy Consultant of the Board of Health.

About 150 nurses were expected to attend the institute; the first night brought out 182, and at the final count 166 had completed the course. A sixth week was necessary to complete the material to be covered and in addition a field trip to the Occupational Therapy and Physical Therapy Departments of Tripler General Hospital was made available on the invitation of Captain Miller of the TGH medical staff.

Miss Schuler would like to thank again the doctors and nurses who participated in the program. In addition, thanks are extended to Mrs. Hill and Miss Newhall, Librarians at the Honolulu County Medical Library, for making readily available the extensive reference material on polio-



myelitis. Appreciation is also expressed to those nurses who contributed fourteen or more extra hours by acting as instructors for return demonstrations at the various hospitals—Miss Mildred Asato, The Queen's Hospital; Mrs. Ora Mae Lytle, St. Francis Hospital; Miss Hannah Richards, Children's Hospital; Mrs. Isabel Medeiros, Kuakini Hospital; Miss Ruth Arnold, Kapiolani Hospital; Mrs. Ethel Hass and Miss Violet Buchanan, Leahi Hospital.

The program and those participating were as follows:

#### First week: Acute Poliomyelitis

1. *Purpose of the Institute and Need for Teamwork in Caring for Poliomyelitis Patients.* Miss Loretta T. Schuler, R. N.
2. *Description of Services for the National Foundation for Infantile Paralysis.* Miss Carolyn Kingdon.
3. *Medical Aspects and Role of the Nurse in Acute Poliomyelitis.* Pauline Stitt, M. D.

#### Second week: Bulbar Poliomyelitis

1. *Bulbar Poliomyelitis.* Major Walton Edwards, M.D
2. *Movie: Nursing Care of Acute Poliomyelitis.*
3. *Emotional Problems of the Handicapped Child and His Parents.* John Lynn, IV, M.D.

#### Third Week: Demonstrations

1. *Hot Pack Demonstration.* Miss Mildred Asato, R. N., assisted by Miss Dorothy Nagano, R. N., R. P. T.
2. *Bed Bath and Handling.* Miss Loretta T. Schuler, R. N.
3. *Movie: Nursing Care of Patient with Muscle Spasm.*

#### Fourth week: Subacute Poliomyelitis

1. *Physical Medicine and Physical Therapy of Subacute Poliomyelitis.* Captain B. L. Miller, M. D.
2. *Physiotherapy Aspect of Subacute Poliomyelitis.* Miss Carol Moyer, R. P. T.
3. *Occupational Therapy Aspects in the Hospital.* Miss Esther Pyun, O. T. R.

#### Fifth week: Convalescent and Chronic Poliomyelitis

1. *The Surgical and Orthopedic Aspects.* J. Warren White, M. D.
2. *The Role of the Nurse, Physiotherapist, Occupational Therapist and Social Worker in Caring for the Poliomyelitis Patient in His Home.* Miss Paula Sorg, R. N., R. P. T., Miss Catharine Nourse, O. T. R., Mrs. Esther Ryan, Medical Social Worker.

A breakdown of nurses attending the course showed 42 from Queen's, 34 from St. Francis, 36 from Kuakini, 9 from Kapiolani, 10 from Children's, 23 from Leahi, 12 office nurses and inactive nurse-housewives.

The enthusiastic participation of this large group of nurses was most gratifying to those who worked so hard to make the institute possible.

## STUDENT NURSES' ORGANIZATION

The Hawaii Organization of Student Nurses was first started in January 1949 after a suggestion made at the annual convention of the Territorial Nurses' Association. With Miss Esther Ho of St. Francis Hospital elected as its first president, the objective was "to promote friendship and understanding among the accredited schools of nursing through social gatherings, educational activities and organizational work." Monthly meetings were held and dues were set at 25 cents per student.

Officers this year were: Helen Goshi, Queen's Hospital, President; Frances Kimura, St. Francis Hospital, Vice President; Emily Brown, St. Francis Hospital, Recording Secretary; Katsuko Taki-guchi, Queen's Hospital, Corresponding Secretary; June Okuhama, Queen's Hospital, Treasurer; Blanche Crivello, St. Francis Hospital, Educational & Publicity Committee Chairman; Betty Yamaguchi, Queen's Hospital, Social Committee Chairman.

Faculty advisors were Miss Inez Lange, Educational Director, St. Francis Hospital and Miss Esther Conroy, Educational Director, Queen's Hospital. Mr. J. Edwin Whitlow was Neutral Senior Advisor.

Activities for the year 1949-50 included a fashion talk by Mrs. Delpech of McNerny's Department Store, a talk on "What the Accredited Program Will Mean to You as Graduates" by Miss Gladys Benz, Director of Advisory Service to the State Leagues of Nursing Education, a Christmas house party at Queen's Hospital, and a benefit dance at the Nuuanu YMCA given in the latter part of April.

Newly elected officers for 1950-51 are:

**June Okuhama**, Queen's Hospital, President  
**Blanche Crivello**, St. Francis Hospital, Vice President  
**Nancy Miyasato**, Queen's Hospital, Recording Secretary  
**Lora Hee**, St. Francis Hospital, Corresponding Secretary  
**Hope Chow**, St. Francis Hospital, Treasurer  
**Harriet Ogata**, Queen's Hospital, Chairman, Educational and Publicity Committee.  
**Florence Ayers**, St. Francis Hospital, Social Committee Chairman  
**Mary Stanley**, Queen's Hospital, Chairman, Constitutional Committee

Introduction of the new officers was held at the Territorial Nurses' Association annual convention in September 1950.



## ADDRESS OF THE RETIRING PRESIDENT, TERRITORIAL PRACTICAL NURSES' ASSOCIATION

Banquet, Queen's Surf, June 24, 1950

MRS. KATIE CHUN\*

Chairman, Members and Guests:

On behalf of the outgoing officers, I wish to congratulate the incoming officers upon their election to office and wish them much success throughout the coming year.

There are times when it is difficult to find words for the proper expression of one's sentiments. This is such an occasion. My chief feeling tonight is one of relief that the year's work has come to an end. I want to thank the members for the privilege of serving the organization as the president in the past year. I have enjoyed my term of office and the many pleasant experiences we have had together. To me, the year has been a successful one; but I realize that this would not have been possible by my efforts alone. I have enjoyed your good will and earnest cooperation at all times. Where I have succeeded you have been generous in your praise; where I have failed you have been charitable and sympathetic. Because of these, my term of office will always be remembered as one of the most pleasant experiences in my life.

I learned that my work did not only begin in the club room but in working with the public. I feel that it was one of my duties to assist in promoting good feeling, in using our resources, and in encouraging those qualified to join our organization. I hope that we have fulfilled the purposes for which we were organized.

What have we done in our past year's committee work?

### 1. Membership

Remembering that this was our first year together, our membership has grown from 15 to a total of 138 members today.

### 2. Finance

Our finances have grown from \$17 to \$300 today.

### 3. Constitution and By-Laws

Our constitution and by-laws have been drafted, adopted and approved. Now there is room for revision.

### 4. Program and Entertainment

We have gone a long way in having educational programs covering Mental Hygiene, Tuberculosis, Cancer Nursing and the showing of a nutrition film to the membership.

### 5. Publicity

Through our local newspapers, we have had generous publicity.

\*Licensed practical nurse, Leahi Hospital staff.

Now, what about this year's plans? We need to:

1. Expand our membership on Oahu.
2. Expand our membership to the outside Islands.
3. Continue to sell our organization to the public.
4. Think about becoming members of the National Organization. Then, what about sending a delegate to the next National Convention to be held in May, in Atlantic City?

In closing, I want to thank you again for the privilege and for your help. I shall continue to be willing to carry on in this organization in any way you see fit.

## PRACTICAL NURSE ASSOCIATION ELECTS OFFICERS

The Territorial Practical Nurse Association, now beginning its second year, has recently elected officers. They are:

President—**Mrs. Lydia Dupont**  
Vice President—**Mrs. Margaret Perreira**  
2nd Vice President—**Mrs. Margaret Kauka**  
Secretary—**Miss Pearl Lai**  
Treasurer—**Mrs. Elizabeth Meek**  
Corresponding Secretary—**Miss Rita E. Nailima**

The organization is growing steadily and urges all licensed practical nurses not only on the island of Oahu, but on the other islands to join the group. They are working together to help their group, just as professional nurses are doing. At a recent meeting with the Private Duty Practical Nurses, they approved the personnel policies for Private Duty Practical Nurses. They hope to form a Private Duty Section of their organization and thus further assist themselves. They are also taking an active part in the recruitment program for nurses for the Disaster Program.

We are all happy to see them take an active part in their own program and know they will make a valuable contribution to nursing.

## NEWS NOTES

### Children's Hospital

Recent members of the hospital staff:

**Miss Lucille Carpenter**, Educational Director, is a graduate of Adelphi College School of Nursing, Garden City, New York. She also studied at St. Lawrence University and did graduate work in clinical instruction at New York University. Before coming to Honolulu, Miss Carpenter was Clinical Instructor and Assistant Director of Nursing at Kingston Hospital, Kingston, New York.

**Miss Mary Louise Barrette**, Surgical Supervisor, is a graduate of Memorial Hospital School of Nursing, Worcester, Massachusetts. Miss Barrette did graduate studies in tuberculosis, anesthesia and surgery at the same hospital.

**Miss Kay Imamura**, graduate of the Philadelphia School of Occupational Therapy and Washington University, St. Louis, Missouri, joined the staff as occupa-

tional therapist after recently completing a year's internship at Los Angeles General Hospital.

**Miss Betsy Takahashi** has recently re-joined the staff after completing a year's scholarship in orthopedic and poliomyelitis nursing at Boston University. The scholarship was granted through the local chapter of the Infantile Paralysis Foundation.

**Miss Hisaka Yashida** attended a three-week institute on rheumatic fever given at the University of California in Berkeley, on a scholarship which was financed by funds allotted to the Territorial Department of Health by the National Heart Association, U. S. P. H. S.

### The Queen's Hospital

**Mrs. Rase Kim Chang**, formerly a medical supervisor at Queen's, has returned recently as assistant director of nurses. During her residence in Pittsburgh, Pennsylvania for the past three years, Mrs. Chang completed work for her master's degree at the University.

Two recent arrivals from Dayton, Ohio are **Misses Kathryn Fax** and **Marilyn Hunt**. Both are clinical instructors at the Queen's School of Nursing.

The class of 1950 was graduated on August 24 at 5 p. m. in the Andrews Memorial Amphitheatre at the University of Hawaii. Dr. Ira V. Hiscock was guest speaker. About 35 of the graduates will join the staff of The Queen's Hospital. Some will be employed at Hilo, some at Kona and others at Children's Hospital in Honolulu. One or two plan to go to Maui and Kauai.

Those who graduated:

**Currier, Bonnie Lau**  
**Fujimata, Teruka**  
**Gashi, Helen**  
**Harai, Faith**  
**Hasegawa, Ethel**  
**Hiramato, Martha**  
**Hiramata, Mieka**  
**Hariuchi, Gladys**  
**Ishida, Satsumi**  
**Ishihara, Haruka**  
**Izawa, Fukika**  
**Jacobs, Betty Jean**  
**Kamasaki, Emika**  
**Kim, Mary**  
**Kubayama, Elinar**  
**Kunishige, Jessie**  
**Kuniyuki, Sadaka**  
**Lee, Phyllis**  
**Lee, Victoria**  
**Mana, Marian**  
**Marutani, Alice**  
**Matsumata, Grace**  
**Miyasata, Helen**  
**Marimata, Mieka**  
**Marishita, Michiya**

**Nagatani, Kiyano**  
**Nakamoto, Misaye**  
**Nakamura, Takaka**  
**Nakaya, Teruya**  
**Ohama, Florence**  
**Okahata, Margaret**  
**Oshita, Nancy**  
**Saiga, Kazumi**  
**Sakamata, Jane**  
**Shigihara, Sheila**  
**Shiasaki, Judy**  
**Stanley, Elsa Anne**  
**Suzuki, Gene**  
**Takahashi, Sumika**  
**Takeuchi, Myrtle**  
**Tayama, Kimie**  
**Uechi, Rieka**  
**Uehana, Tatsuka**  
**Wada, Elaine**  
**Wada, Glaria**  
**Watanabe, Elsie**  
**Watanabe, Ruth**  
**Yamaguchi, Betty**  
**Yasuda, Margaret**  
**Yagi, Yurika**

### St. Francis Hospital

Three new faculty members have been added to the St. Francis Hospital School of Nursing Staff. The **Misses Leah Bigalow** and **Margaret Schuldheisz** are replacing the **Misses Mary Ann Mikulic** and **Geraldine Wells** as clinical supervisors. Miss Wells and Miss Mikulic are returning to the mainland to further their education.

**Miss Karen Tanaka**, a graduate of St. Francis Hospital School of Nursing will be the new assistant nursing arts instructor under **Mrs. Ora Lytle** who will take **Miss Inez Lange's** place. Miss Lange is returning to the main-

land to work on her master's degree at the University of Minnesota.

**Miss Bigalow** received her Bachelor of Science degree from the College of Holy Names in Oakland, California. **Miss Schuldheisz** graduated from the San Francisco College for Women. She served with the Army Nurse Corps from April 1942 to November 1945.

**Mrs. Lytle** has a Bachelor of Arts degree from Oregon State College. Up to the present, she has been medical and surgical supervisor on the second floor. She will be relieved of this work to assume the position of nursing arts instructor.

**Sister Marie Therese** returned from the mainland at the end of July. She attended an institute on the Care of the Premature Infant. Her trip was sponsored by the Bureau of Maternal and Child Health, Territorial Department of Health. Sister received her Bachelor of Science degree in nursing education from the University of Dayton in June of this year.

Other additions to the St. Francis Hospital Staff are:

**Mrs. Ellen Strand**, graduate of Lancaster General Hospital School of Nursing, Lancaster, Pennsylvania.

**Miss Judith Yamada**, graduate of St. Francis Hospital School of Nursing, Honolulu.

**Miss Florence Raemisch**, graduate of Queen of Angels Hospital School of Nursing, Los Angeles, California.

**Mrs. Grace Davis**, graduate of St. Francis Hospital School of Nursing, Poughkeepsie, New York.

**Miss Gail Tomes**, graduate of Sacred Heart General Hospital School of Nursing, Eugene, Oregon.

**Miss Theresa Jaw**, graduate of St. Francis Hospital School of Nursing, Honolulu; post-graduate training in pediatric nursing at Cooke County Hospital, Chicago, Illinois.

**Miss Edith Kubajira**, graduate of St. Francis Hospital School of Nursing, Honolulu.

**Miss Gladys Matsunaga**, graduate of St. Francis Hospital School of Nursing, Honolulu; post-graduate training in premature infant care at Johns Hopkins Hospital, Baltimore, Maryland; Michael Reese Hospital, Chicago and St. Francis Hospital, Peoria, Illinois.

**Miss Ruth Kurz**, graduate of Nazareth School of Nursing, St. Joseph Infirmary, Louisville, Kentucky.

**Miss LaVerne Pfaadt**, graduate of Nazareth School of Nursing, St. Joseph Infirmary, Louisville, Kentucky.

**Miss Alice Louise Schepers**, graduate of Nazareth School of Nursing, St. Joseph Infirmary, Louisville, Kentucky.

**Miss Mary Millicent Spanyer**, graduate of Nazareth School of Nursing, St. Joseph Infirmary, Louisville, Kentucky.

**Miss Faith Wheeler**, graduate of Nazareth School of Nursing, St. Joseph Infirmary, Louisville, Kentucky.

**Mrs. Ramana Tehera**, graduate of St. Francis Hospital School of Nursing, Honolulu.

**Miss Laurdes Ganare**, B.S., St. Mary's College, Xavier, Kansas, will teach physical education to the student nurses. **Mrs. Narma Fisher Larson**, B.S., University of Hawaii, returned early in August to accept a supervisory position.

Forty-one seniors graduated at the Cathedral of Our Lady of Peace on Sunday, August 27, at 3 p. m. They are:



**Akbay, Priscilla**  
**Almante, Virginia**  
**Asata, Esther**  
**Au Hay, Barbara**  
**Bernard, Ramona**  
**Brawn, Emily**  
**Burke, Annie Marie**  
**Cabag, Elaine**  
**Ebata, Dale**  
**Fantes, Elizabeth**  
**Garcia, Josephine**  
**Gaa, Eleanor**  
**Higaki, Tsuyuka**  
**Hanma, Jean**  
**Ita, Geraldine**  
**Kaku, Mazie**  
**Kamiya, Barbara**  
**Kawachika, Hatsumi**  
**Kawamata, Grace**  
**Kim, Marie**  
**Kimura, Evelyn**

**Kajira, Yukika**  
**Kakubun, Katherine**  
**Leandra, Veranica**  
**Lee, Betty I. S.**  
**Mew, Betty**  
**Marikawa, Florence**  
**Murakami, Etsuka**  
**Murakami, Eunice**  
**Nakamura, May**  
**Nakashima, Teruka**  
**Nishimura, Maydell**  
**Oganeku, Ida**  
**Sabala, Juanita**  
**Sambrano, Lydia**  
**Sata, Denis**  
**Shishida, Jane**  
**Siu, Tung Chin**  
**Sur, Winifred**  
**Watanabe, Violet**  
**Yaung, Leonara**

### Kuakini Hospital

**Miss Nancy Tingley** joined the Kuakini Hospital School of Nursing on Aug. 1 as Nursing Arts Instructor. Miss Tingley is a graduate of St. Luke's School of Nursing, New York City.

**Mrs. Isabel Medeiros**, graduate of Bethesda Hospital School of Nursing, Zanesville, Ohio has joined the staff as clinical instructor.

**Mrs. Gladys Jacobs**, formerly at Kapiolani, is now taking over the duties of supervisor on the obstetrical department.

Twenty-six seniors will graduate on Saturday, Oct. 7 at 7:30 p. m. at St. Andrew's Cathedral. All nurses and friends are cordially invited to attend. The graduates are:

**Claire T. Abe**  
**Ella A. S. Chun**  
**Shian T. Danbara**  
**Jayce A. Imada**  
**Sandra S. Imai**  
**Emily K. Kaaua**  
**Chiyaka Kaneshira**  
**Chiya Kana**  
**Ramana K. Kimura**  
**Taeko Kunimitsu**  
**Yukika Matsumura**  
**Lucy M. Nakada**  
**Ayaka Nishihira**

**Mitsuka Nishimata**  
**Shigeka Ogata**  
**Edith K. Shimabukura**  
**Alice M. Shiraishi**  
**Hilda M. Shiroma**  
**Ruth K. Sunakoda**  
**Mary M. Takaki**  
**Gladys H. Takemura**  
**Mae H. Tamaribuchi**  
**Darathy J. Texeira**  
**Aika Uesataja**  
**Kikue Uyesu**  
**Lillie Yuriko Yamaguchi**

### Nurses Association County of Kauai

The Kauai Nurses Association will sponsor two yearly nursing school scholarships to be presented to their local high school graduates as a method of improving nursing service on Kauai. Selections will be made by the Scholarship Committee of the KNA and the student may choose any hospital. There will be no obligation attached to the scholarship with the exception that the student agree to serve as a graduate nurse on Kauai for one year.

The energetic KNA will raise funds for the scholarship fund in various ways, one of the most successful being the white elephant auction. They have other ideas, too, that sound like a lot of fun for everybody. For example, a rummage sale, a barn dance and raffle, doll dressing for tourist trade.

### Distinguished Visitors

It was with a great deal of pleasure that the Nurses' Association, Territory of Hawaii welcomed **Miss Shirley Titus** to our recent Territorial Convention. Miss Titus, Executive Director of the California State Nurses' Association, is chairman of the ANA Committee on the Employment Conditions of Registered Nurses and was sent to us at our request by the American Nurses' Association. I am sure we all enjoyed and profited a great deal by her visit. Come back again soon, Miss Titus.

**Miss Mary Samagyi**, Director of Nurses at San Joaquin General Hospital, Franch Camp, California was a recent visitor in the office.

**Miss Mary Jahnsan**, one of the charter members of the Nurses' Association, Territory of Hawaii, is now confined to the Wahiawa General Hospital. We all sincerely hope that Miss Johnson will soon be up and about again. She will welcome any visitors or cards and letters you can send her.

### CANCER INSTITUTES

Seldom do the nurses of Hawaii have the opportunity that is being extended to them this October. Miss Rosalie Peterson, Senior Nurse Consultant, National Cancer Institute, United States Public Health Service, will conduct a series of institutes on each island for the registered nurses in that area.

Though the program will vary a little with each island, in general, subjects that will be covered are (1) Medical nursing care of a. Breast b. Female genital organs, c. Gastro-intestinal cancer with nursing care of the colostomy; (2) Emotional and psychological factors pertaining to the cancer patient and (3) Rehabilitation of the cancer patient.

Miss Peterson will have very able assistance in others well known to our Territory—Miss Clair Canfield and Miss Vera Hansel.

The U. S. P. H. Service is paying Miss Peterson's travel expenses to the islands and her travel and living expenses while here will be covered by the Hawaii Cancer Society.

All registered nurses are urged to watch their local papers for last minute information about these institutes. The dates are:

Island of Hawaii—Oct. 16, 17  
 Island of Maui—Oct. 18-19  
 Island of Oahu—Oct. 20  
 Island of Kauai—Oct. 23-24

The University of Hawaii is offering a two credit course under Miss Peterson in cooperation with the Hawaii Cancer Society from Oct. 2-Oct. 13. This course will cover 60 hours and is open to registered nurses in the teaching field, including public health nurses. Enrollment is limited to 25 students.



# S P E R M I C I D A L T I M E



To be completely safe, a reliable contraceptive must exhibit the highest spermicidal power possible . . after dilution. In Koromex (jelly or cream) you have the fastest spermicidal time measurable . . when tested . . according to the Brown & Gamble technique representing a 1:10 dilution.

ACTIVE INGREDIENTS: BORIC ACID 2.0% OXYQUINOLIN BENZOATE 0.02% AND PHENYLMERCURIC ACETATE 0.02% IN SUITABLE JELLY OR CREAM BASES



## KOROMEX

®

A CHOICE OF PHYSICIANS

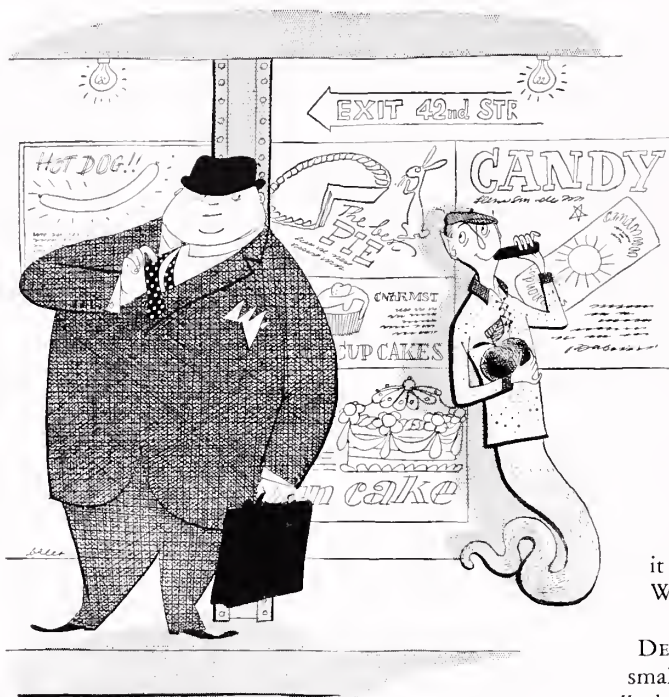


HOLLAND-RANTOS COMPANY, INC. • 145 HUDSON ST., NEW YORK 13, N. Y.

MERLE L. YOUNGS

P R E S I D E N T

# When all signs point to forbidden foods...



● When he's hungry—when his gourmand's soul begins to rebel against the dull, plodding pace of the reducing diet—this is when physician and patient alike welcome a relatively safe, effective central stimulant. ● With DESOXYN Hydrochloride, small doses are sufficient to produce the desired cerebral effect—  
anorexia, elevation of mood and desire for activity—with relative freedom from undesirable side-effects. Smaller dosage is possible because, weight for weight, DESOXYN is more potent than other sympathomimetic amines. Other advantages are DESOXYN's faster action, longer effect. One 2.5-mg. tablet before breakfast and another about an hour before lunch are usually sufficient. A third tablet may be taken about 3:30 in the afternoon, but after 4 p.m. it may cause insomnia in some persons. With small oral doses, no pressor effect has been observed. ● Why not give DESOXYN a trial? Unless contraindicated, small doses are harmless. And small doses well placed may mean the difference between success and failure in the outcome of the reducing regimen. **Abbott**

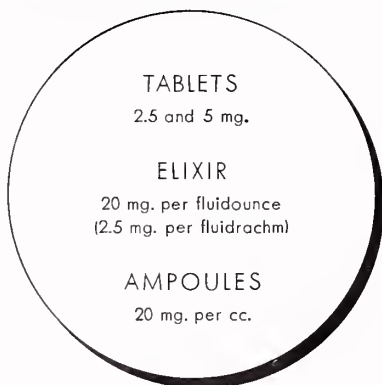
note the name



## DESOXYN<sup>®</sup>

### hydrochloride

(METHAMPHETAMINE HYDROCHLORIDE, ABBOTT)



3

# Questions every doctor is asked

## 1. "Which evaporated milk should I use in my baby's formula?"

When you answer "Carnation," you name the milk which has been approved by the medical profession for generations. And Carnation protects your recommendation by maintaining unsurpassed standards of safety, uniformity, and nutritive value. Every can of Carnation Milk is processed with "prescription accuracy"...in Carnation's *own* evaporating plants...under Carnation's *own* strict supervision.

## 2. "Should I change to bottled milk when my baby goes off formula?"

Medical experience indicates that there is no need to change to another form of milk at this stage of baby's development. Baby still needs the protection of Carnation's constant uniformity and safety. Because Carnation is *soft-curd* milk—heat refined and homogenized—it is easier to digest. Carnation diluted with an equal amount of water is whole milk of the highest quality.

## 3. "How can I wean my baby from bottle to cup drinking?"

Baby's natural resistance to change is increased if the cup contains milk with a strange new taste. And the use of a different form of milk can lead to digestive upsets. Doctors have found that the combination of Carnation's familiar flavor and uniform composition facilitate the weaning process...while its unsurpassed nutritional qualities encourage the uninterrupted healthy growth of the baby.

The Milk Every Doctor Knows



"FROM CONTENTED COWS"







COUNCIL ACCEPTED

*new broad-spectrum antibiotic  
orally effective—well tolerated*

CRYSTALLINE

# Terramycin

HYDROCHLORIDE

Active against specific organisms in the  
bacterial, rickettsial and protozoan groups

**Suggested for:** *acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to E. coli, A. aerogenes, Staphylococcus albus and aureus, and other Terramycin-sensitive organisms; brucellosis (abortus, melitensis, suis); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsial pox.*

**Dosage:** On the basis of findings obtained at over 100 leading medical research centers, 2 to 3 Gm. daily by mouth in divided doses q. 4 or 6 h. is suggested for acute infections.

**Supplied:** 250 mg. capsules, bottles of 16 and 100;  
100 mg. capsules, bottles of 25;  
50 mg. capsules, bottles of 25.

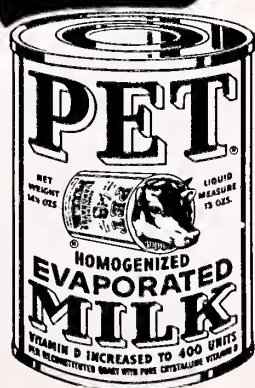
**Pfizer**

*Antibiotic Division*

CHAS. PFIZER & CO., INC., Brooklyn 6, New York



**Favored for  
Infant  
Formula**



## **No One knows Better Than You ...A Doctor is Human, Too!**

Like thoughtful physicians everywhere, your interest in patients extends beyond professional treatment. For example, you make sure that new babies get proper food, wisely managed, safely prepared for best growth! But you also try to keep cost down . . . because you know that most parents need every spare penny they can save!

Pet Evaporated Milk helps you solve both problems! It assures babies of optimal nutrition and gives parents maximal economy. Pet Milk is complete in the food values of whole milk . . . and it's practically as easy to digest as human milk . . . yet Pet Milk costs less than other forms!

You can be sure of this, too! Pet Milk is always surely safe . . . as if there were no germs of disease in the world . . . because Pet Milk is sterilized in a sealed container!

So for safety, nutrition, and economy, too . . . suggest Pet Milk, *the first evaporated milk*, for the formula of babies in your care!

# BIRTCHEr

## *Crystal* BANDMASTER

### SHORT WAVE DIATHERM with the TRIPLE INDUCTION DRUM

The Bandmaster has  
been approved or  
accepted by  
the following:

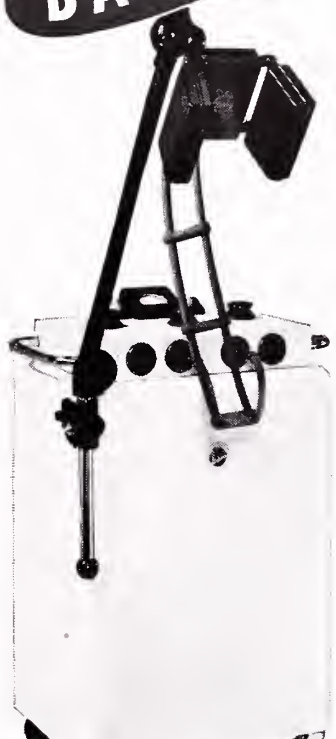
A.M.A. Council on  
Physical Medicine

Federal Communications  
Commission

Underwriters'  
Laboratory

Also the Canadian  
Department of Transport  
and Canadian Standards  
Association

The Bandmaster Diatherm with the Triple Drum provides better diathermy and affords application of the large area technic which is being widely recognized over other methods of producing heat in the tissues.



Considerable total energy may be introduced into the deeper tissues without excessive heating of outer surfaces. Crystal control assures frequency stability for life of the unit.

Reprint of diathermy technics mailed free on request. Write "Bandmaster Booklet" on your prescription blank or clip this advertisement to your letterhead and mail to:



**THE BIRTCHEr CORPORATION**  
5087 Huntington Drive • Los Angeles 32, Calif.

To: The Birtcher Corporation. Dept. HA.  
5087 Huntington Drive, Los Angeles 32, Calif.  
Please send me new treatment chart for LARGE AREA TECHNIC, and new booklet "The Simple Story of Short Wave Therapy."

Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_

The  
"stock in trade"  
of  
insurance companies  
varies little . . .

But  
the handling of that  
stock, the service  
that goes with it,  
varies a great deal.

That  
is why more and more  
insurance-minded busi-  
ness and professional  
men are using the  
facilities of The Home.

**HOME**  **INSURANCE CO.  
OF HAWAII, LTD.**

HOME INSURANCE BLDG. • 129 S. KING ST. • HONOLULU, HAWAII, U.S.A.

KING ST., BETWEEN FORT AND BISHOP

TELEPHONE 6025





"Premarin"—a naturally occurring conjugated estrogen which has long been a choice of physicians treating the climacteric—is earning further clinical acclaim in the treatment of functional uterine bleeding.

The aim of estrogenic therapy in functional uterine bleeding is to bring about cessation of bleeding, and to produce subsequent regulation of the cycle. Once hemostasis is achieved, the maximum daily dosage of "Premarin" must be continued to prevent recurrence of bleeding. This schedule forms part of cyclic estrogen-progesterone treatment for attempted salvage of ovarian function.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.



**An "estrogen of choice  
for hemostasis  
is 'Premarin'  
in tablets of 1.25 mg. ...  
The usual dose for hemostasis  
is 2 tablets three times a day.  
If bleeding has not decreased  
definitely by the third day of  
treatment the dosage level  
may be increased by  
50 per cent."\***

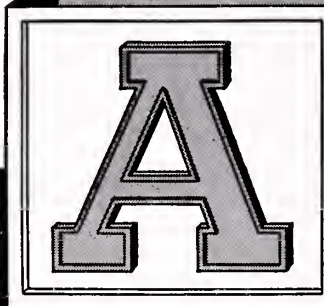
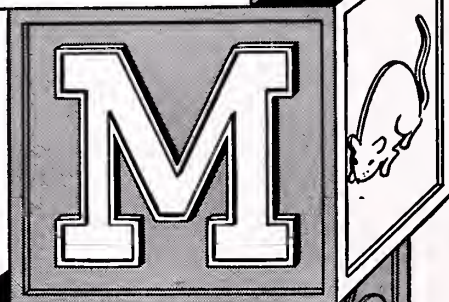
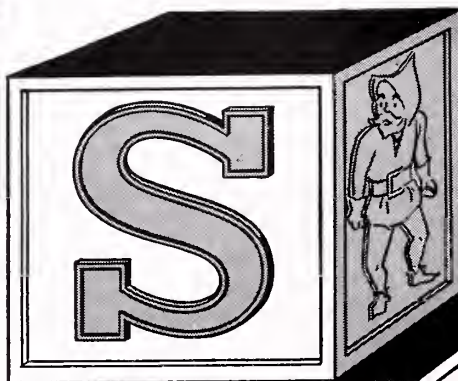
\*Fry, C. O.: J. Am. M. Women's A. 4:51 (Feb.) 1949

**"PREMARIN"®**

*Estrogenic Substances (water-soluble)  
also known as Conjugated Estrogens (equine)*

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

Ayerst, McKenna & Harrison Limited  
22 East 40th Street, New York 16, N. Y.



**builds  
husky  
babies**



Ready-to-feed S-M-A® is patterned after human milk. Quantitatively and qualitatively, its content of protein, fats, carbohydrates, essential minerals and vitamins is designed to provide a complete nutritional base for sturdy growth. Many years of clinical experience proves S-M-A is good for all babies.

S-M-A Concentrated Liquid—cans of 14.7 fl. oz.

S-M-A Powder—1 lb. cans.

*Wyeth* Incorporated • Philadelphia 3, Pa.

*Wyeth*



# Ships kept getting bigger and **BETTER!**



In its early years, Hawaii could ship its products only when some vessel happened to call at an island port. Calls were often few and far between. As island industry grew, it needed *regular* transportation to the mainland. A modest start was made in that direction with the first Matson vessel... the little brig, LURLINE.



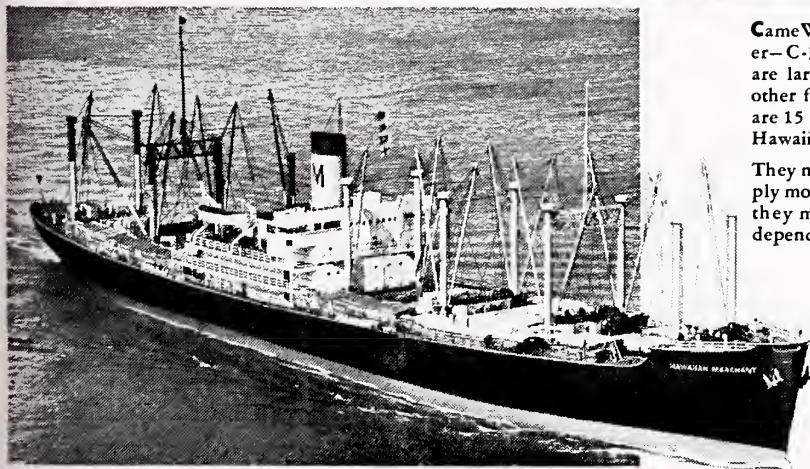
Within twenty years Matson was operating a fleet of sailing ships such as the famous ANNIE JOHNSON. Like great white birds they would glide into Hawaii's ports, bringing up to 1500 tons of merchandise for island people... and sail out again, their hulls heavy with sugar.

Steamers replaced the old windjammers. The Matson fleet kept growing until it included freighters like the MAUNALEI, each hauling more than 10,000 tons of cargo. They met an increasing need for more and more mainland goods for the growing island population, and more cargo space for a bigger and bigger output of sugar, pineapple and other island products.



Came World War II and with it a new type of freighter—C-3's like the HAWAIIAN MERCHANT. They are large, specially designed, and faster than any other freighter in trans-Pacific service. Today there are 15 of them, plus three Liberty ships, in Matson's Hawaiian fleet.

They navigate to and from Hawaii only. They supply more frequent sailings than ever before. And they maintain a time-table regularity... a fast, dependable service exclusively for Hawaii.



## Matson Lines

*This is one of a series of messages giving interesting facts about one of Hawaii's most vital activities... overseas transportation.*





# SURGICAL INSTRUMENTS

by



For over one hundred years, the house of Stille has been engaged in the manufacture of fine surgical instruments. Through those years, the exceptional craftsmanship of Stille instruments has received a great deal of favorable attention all over the world. Medals have been awarded to them at general exhibitions in London, Paris, Brussels, Vienna, and Copenhagen.

Today, as over a hundred years ago, Stille's Instrument firm strives to maintain active and intimate contact with the surgical profession, with the conviction that practical and improved models can be produced only by utilization of the profession's experience and knowledge.

## Neurosurgery

Eye

Nose

Throat, Mouth

Plastic Surgery

Thorax

Ear

## Gynecology

Bone Surgery

General Surgery

Ligature Suture

Endoscopy

Stomach

Liver & Bladder

*Territorial Agents*

## **HOTEL IMPORT COMPANY**

Division The Von Hamm-Young Co., Ltd.

Cooke and Kawaiahao Sts.

Phone 6-3561



# Aureo- mycin



## AUREOMYCIN CRYSTALLINE

### for complications following Acute Infections in Childhood

Now is the season for children to enter upon their scholastic labors, and in most communities to receive either primary, or booster, immunization against several of the common childhood infections. Reliance must be placed upon antibiotics to control the secondary invaders which may follow these infections. Pediatricians are increasingly turning to aureomycin for this purpose, because of its wide range of activity against the common Gram-positive and Gram-negative organisms.

Aureomycin is also indicated for the control of the following infections:

Acute amebiasis, bacterial infections associated with virus influenza, bacterial and virus-like infections of the eye, bacteroides

septicemia, boutonneuse fever, brucellosis, chancroid, Friedländer infections (*Klebsiella pneumonia*), gonorrhea (resistant), Gram-negative infections (including those caused by some of the coli-aerogenes group), Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, peritonitis, pertussis infections (acute and subacute), primary atypical pneumonia, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, sinusitis, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), tularemia, typhus and the common infections of the uterus and adnexa.

**Capsules:** Bottles of 25, 50 mg. each capsule. Bottles of 16, 250 mg. each capsule.

**Ophthalmic:** Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

## *An Observation on the Accuracy of Digitalis Doses*

*Withering* made this penetrating observation in his classic monograph on digitalis: "The more I saw of the great powers of this plant, the more it seemed necessary to bring the doses of it to the greatest possible accuracy."<sup>1</sup>

To achieve the greatest accuracy in dosage and at the same time to preserve the full activity of the leaf, the total cardioactive principles must be isolated from the plant in pure crystalline form so that doses can be based on the actual weight of the active constituents. This is, in fact, the method by which Digilanid® is made.

*Digilanid* contains all the *initial* glycosides from *Digitalis lanata* in crystalline form. It thus truly represents "the great powers of the plant" and brings "the doses of it to the greatest possible accuracy".

*Clinical investigation* has proved that Digilanid is "an effective cardioactive preparation, which has the advantages of purity, stability and accuracy as to dosage and therapeutic effect."<sup>2</sup>

*Average dose* for initiating treatment: 2 to 4 tablets of Digilanid daily until the desired therapeutic level is reached.

Average maintenance dose: 1 tablet daily.

Also available: Drops, Ampuls and Suppositories.

1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. 209: 33-41 (Jan.) 1949.

Literature giving further details about Digilanid and Physician's Trial Supply are available on request.

*Sandoz  
Pharmaceuticals*

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, NEW YORK

## INDEX TO ADVERTISERS

	PAGES		PAGES
Abbott Laboratories .....	68	Mead Johnson & Co.....	80
American Factors.....	58	Merck & Company, Inc.....	79
Ayerst, McKenna & Harrison, Ltd.....	73	Parke, Davis & Company.....	2, 3
Birtcher Corporation .....	72	Pet Milk Company.....	71
Borden Company .....	18	Pfizer & Co., Inc.....	70
Carnation .....	69	Philip Morris & Co., Ltd., Inc.....	6
Dairymen's Association, Ltd.....	4	Sandoz Pharmaceuticals .....	78
Don Baxter, Inc.....	16	Schering Corporation .....	5
Eli Lilly and Company.....	1, Insert	Schuman Carriage Co. Ltd.....	10
Holland Rantos Company, Inc.....	67	Searle & Co.....	57
Home Insurance Co.....	72	Sharp & Dohme.....	11
Hotel Hana-Maui .....	8	Squibb & Sons.....	14, 15
Hotel Import Co.....	76	Upjohn .....	12
International Travel Service.....	8	Wander Company .....	9
Lederle Laboratories .....	77	Winthrop-Stearns, Inc. ....	7
Matson .....	75	Wyeth Incorporated .....	13, 74
McArthur & Summers.....	36, 39, 49, 52		



# For Safe Symptomatic Relief During the "Late" Hay Fever Season



There are good reasons why many allergists consider "late" hay fever a more serious threat than the Spring and Summer types of seasonal allergy: ragweed pollens cause a greater incidence of hay fever than all other pollens combined; more pollens are in the air during the ragweed season than at any other time; and since "the United States is the favorite habitat of ragweed, it has the dubious distinction of harboring more hay fever victims than all the rest of the world together."<sup>1</sup>

Fortunately, more and more patients each year are enjoying the therapeutic benefits of Neo-Antergan® Maleate. Because of its safe and strikingly effective action in relieving the distressing symptoms of allergy, Neo-Antergan has become a favorite antihistaminic with physicians and patients—in every season of the year.

**Neo-Antergan is advertised exclusively to the medical profession. Your patients can secure its benefits only through your prescription.**

Neo-Antergan Maleate is stocked by your local pharmacy in 25mg. and 50mg. tablets. Complete information concerning its clinical use will be sent on request.

<sup>1</sup>Cooke, R. A.: *Allergy in Theory and Practice*, Philadelphia: W. B. Saunders Company, 1947, p. 186



**MERCK & CO., INC.**  
Manufacturing Chemists  
RAHWAY, NEW JERSEY

## Neo-Antergan®

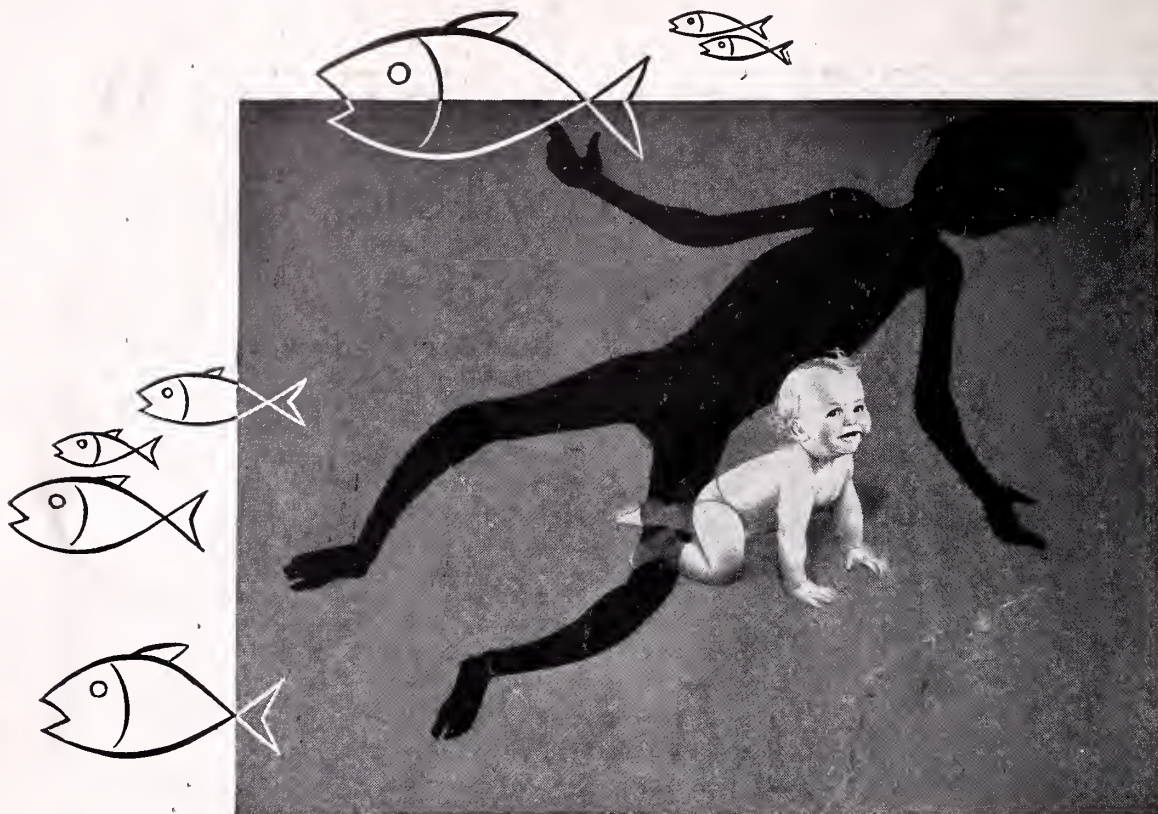
MALEATE

(Brand of Pyranisamine Maleate)

(N-p-methoxybenzyl-N',N'-dimethyl-N-a-pyridylethylenediamine maleate)



COUNCIL ON PHARMACY AND CHEMISTRY ACCEPTED



Supplements the sun...

*removes the shadow of RICKETS*

Rickets may be found in apparently healthy and well nourished infants due to an insufficient intake of vitamin D plus inadequate exposure to ultraviolet rays.

It is now generally accepted that a vitamin D supplement should be given regularly not only to infants but to older children and adolescents. Mead's Oleum Percomorphum With Other Fish Liver Oils and Viosterol is useful for this purpose.

#### Mead's Oleum Percomorphum

1. Is a highly potent† source of natural vitamins A and D.
2. May be given in drop doses that are easily administered and well tolerated, and is supplied in capsule form also.
3. Has a background of sixteen years of successful clinical use.

†Potency: 60,000 U.S.P. units of vitamin A and 8500 U.S.P. units of vitamin D per gram. Each drop supplies 1250 units of vitamin A and 180 units of vitamin D; each capsule, 5000 units of vitamin A and 700 units of vitamin D.

Supplied in 10 cc. and 50 cc. bottles; and in bottles of 50 and 250 capsules.

SPECIFY

MEAD'S

MEAD JOHNSON & CO.  
EVANSVILLE 21, IND., U.S.A.



# AWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

THE N.Y. ACADEMY  
OF MEDICINE  
DEC 21 1950  
LIBRARY

WE 10

NOVEMBER-DECEMBER, 1950

NUMBER 2



PUBLIC HEALTH IN HAWAII Ira V. Hiscock.....	99
PRIMARY ANORECTAL ABSCESS V. C. Waite.....	113
PRESIDENT'S PAGE .....	116
FEATURES .....	117
INTER-ISLAND NURSES' BULLETIN .....	133

*Sig.*

—or “let it be marked”— indicates directions for the patient’s use which are to be marked on the prescription package label.

Detailed literature on Lilly pharmaceuticals, although freely available to physicians, is not supplied to the laity. The physician, we believe, has the right to determine what medical information should be given to his patient.



ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.



*make estrogen therapy  
more economical with*

***Steri-Vials Theelin in Oil:*** vials of 10 cc., 1 mg.

(10,000 International Units) per cc.

***Steri-Vials Theelin Aqueous Suspension:*** vials of 10 cc., 2 mg.

(20,000 International Units) per cc.

Theelin in Oil is also available in 1-cc. ampoules containing 0.2 mg., 0.5 mg., and 1 mg. Theelin per cc.; Theelin Aqueous Suspension in 1-cc. ampoules containing 1 mg., 2 mg., and 5 mg., and in 5-cc. Steri-Vials containing 5 mg. of Theelin per cc.

**PARKE, DAVIS & COMPANY**

# THEELIN

## AQUEOUS SUSPENSION

*and*

# THEELIN

## IN OIL

*in* STERI-VIALS®



When prolonged estrogenic therapy is required, as in the treatment of the menopausal syndrome, increased economy is achieved with STERI-VIALS THEELIN IN OIL and STERI-VIALS THEELIN AQUEOUS SUSPENSION. Steri-Vials are rubber-diaphragm-capped 10 cc. vials from which repeated doses can be withdrawn under sterile precautions. Further advantages result from the high potency and chemical purity of THEELIN.

It effectively relieves menopausal symptoms, is well tolerated, and confers a sense of well-being associated with naturally-occurring estrogens. Its availability as oily solution or watery suspension permits flexibility in administration and individualized therapy. THEELIN IN OIL is quickly absorbed and its therapeutic action is promptly manifested. Absorption of THEELIN AQUEOUS SUSPENSION is slower and more sustained.



# HOW TO GET MORE MILK NUTRIENTS into JUNIOR

Many a youngster (or grownup) who hesitates at "white" milk will welcome the change to Dari-Rich.

Served hot at breakfast and frosty-cool at hunger times throughout the warm day, this whole-milk dairy food is an excellent body-building energy drink.

Made with whole milk, containing the full quantity of butter-fat, Dari-Rich provides all of the regular whole-milk vitamins, protein, calcium and other minerals in their highly usable form . . . with the additional energy value of Dari-Rich chocolate, one of the finest pure chocolates prepared.

Dari-Rich is processed and delivered exclusively by Dairymen's in Hawaii, and is available in sanitary Pure-Pak cartons at the store . . . or bottles at the door.

***Dairymen's***  
**ASSOCIATION, LTD.**

*A Division of Creameries of America, Inc.*



For "Build-up" diets and growing youngsters, recommend hot Dari-Rich for winter



**a  
long  
and  
distinguished  
career  
in  
urography**



# NEO-IOPAX<sup>®</sup>

(brand of sodium iodomethamate)



An 18 year history of dependable roentgenograms obtained without harm to the patient distinguishes the career of NEO-IOPAX as a diagnostic urographic agent. Since 1932, *hundreds of thousands of doses of* NEO-IOPAX have been injected with virtual freedom from serious untoward reactions. No other urographic contrast medium has equalled the safety record of NEO-IOPAX. No agent, experience with which is limited to a relatively small number of patients, can be deemed to be as safe. Because the patient's life and welfare take precedence over all other considerations in diagnostic investigation of the urinary tract, urologists and roentgenologists will continue to rely—as always—on NEO-IOPAX.

Available as a stable, crystal-clear solution of disodium N-methyl-3, 5-diiodo-chelidamate in 10, 20 and 30 cc. ampuls of 50% concentration. NEO-IOPAX 75% concentration in 10 cc. ampuls, box of 5 ampuls; 20 cc. boxes of 1, 5 and 20 ampuls.

*Schering* CORPORATION · BLOOMFIELD, NEW JERSEY

NEO-IOPAX



# Cadillac

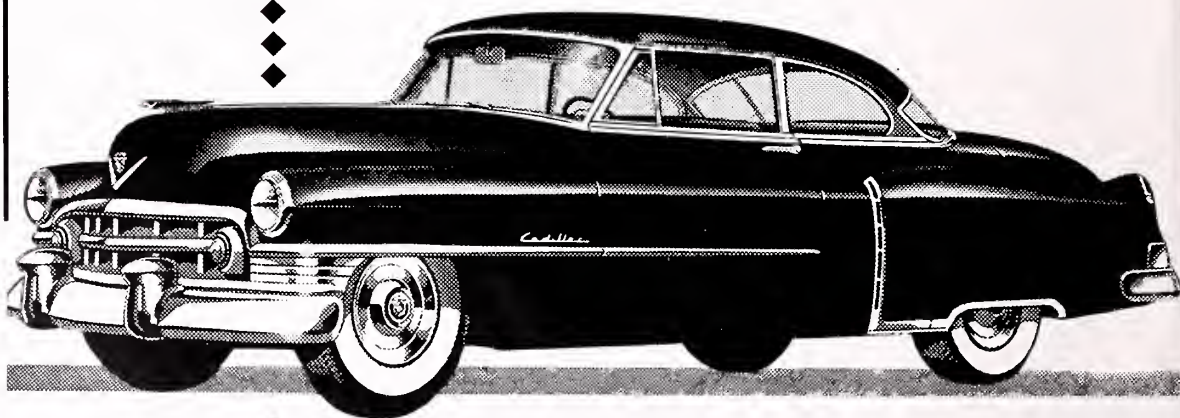
**And a Bright**

*New Year!*

The new year ahead will be a brighter, happier one for you and your family . . . with a gleaming new CADILLAC!

What more thrilling way to celebrate the holidays than the presentation of a CADILLAC . . .

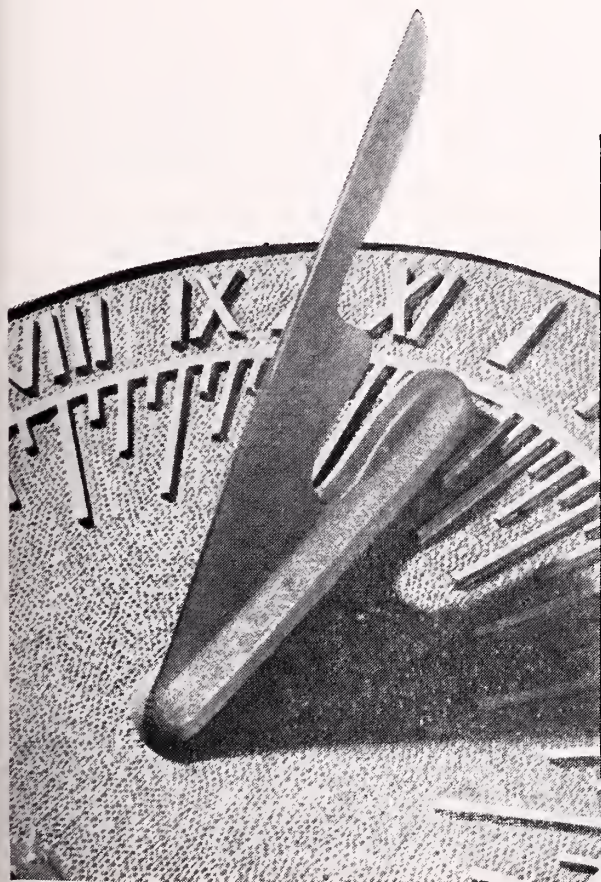
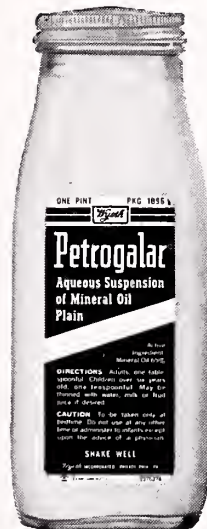
America's most distinguished motor car . . . promising years and years of pleasant, luxurious motoring . . . for you and yours.



**SCHUMAN CARRIAGE COMPANY**

Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU

# HABIT TIME OF BOWEL MOVEMENT



## SAFE . . .

PETROGALAR<sup>®</sup>, given at bedtime—not with meals—has no adverse effect on absorption of nutritive elements. It provides a relatively small but highly effective dose of mineral oil augmented by a bland, hydrophilic colloid base. The result is a soft-formed, easily passed stool, permitting comfortable bowel movement.

If preferred, PETROGALAR may be given thinned with water, milk, or fruit juices—with which it mixes readily.



Wyeth Incorporated, Phila. 3, Pa.



# Nothing Competes with the Lure of Sweets



Use it in Sulfonamide Therapy

● Reactions ranging from mild antagonism to overt rebellion are to be expected when children are confronted with bad-tasting medicine. Contrast this with juvenile enthusiasm for DUOZINE *Dulcet* Tablets.

Here's medicine that sweets-loving small fry (and many adults) really enjoy—sulfadiazine-sulfamerazine disguised in orange-colored, candy-flavored cubes.

Mothers find DUOZINE *Dulcet* Tablets easy to administer in exactly the prescribed dosage. You'll find them effective in many systemic infections. The combined sulfonamides are independently soluble in the urine, with the result that high blood levels can be maintained with small likelihood of crystalluria and renal damage.

DUOZINE *Dulcet* Tablets, sulfadiazine-sulfamerazine in equal parts, are available in 0.3-Gm. and 0.15-Gm. potencies, bottles of 100. Mighty "take-able" medication when sulfonamides are indicated.

Abbott



See that the Rx reads



## DUOZINE *Dulcet*® Tablets

TRADE MARK

(SULFADIAZINE-SULFAMERAZINE COMBINED, ABBOTT)

® MEDICATED SUGAR TABLETS, ABBOTT

# REGARDLESS OF INDICATED THERAPY

## *Nutrition is a Primary Factor*



Whether the condition under treatment is an acute infection, a bowel upset, an injury or a metabolic derangement, nutrition is always a primary factor in therapy. Regardless of other indicated measures, nutritional adequacy is essential for prompt recovery.

When dietary supplementation is the indicated means of increasing the nutrient intake, the food drink, Ovaltine in milk, can prove highly beneficial. Pro-

viding significant amounts of all nutrients considered essential, it virtually assures dietary adequacy when the recommended three glassfuls daily are taken in conjunction with even a fair diet.

Temptingly delicious and readily digested, this dietary supplement fits well into the framework of most indicated diets, and finds ready patient acceptance. Its generous nutrient content is detailed in the table below.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

## *Ovaltine*

Three servings of Ovaltine, each made of  
1/2 oz. of Ovaltine and 8 oz. of whole milk,\* provide:

PROTEIN . . . . .	32 Gm.	VITAMIN A . . . . .	3000 I.U.
FAT . . . . .	32 Gm.	VITAMIN B <sub>1</sub> . . . . .	1.16 mg.
CARBOHYDRATE . . . . .	65 Gm.	RIBOFLAVIN . . . . .	2.0 mg.
CALCIUM . . . . .	.112 Gm.	NIACIN . . . . .	6.8 mg.
PHOSPHORUS . . . . .	.094 Gm.	VITAMIN C . . . . .	30.0 mg.
IRON . . . . .	12 mg.	VITAMIN D . . . . .	417 I.U.
COPPER . . . . .	0.5 mg.	CALORIES . . . . .	676

\*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



# Pure Crystalline Vitamin B<sub>12</sub>

**The Only Form**

**Of This Important**

**Vitamin**

**Official In The U. S. P.**

## PREFERRED BECAUSE

potency, purity, and lack of toxicity of *crystalline* vitamin B<sub>12</sub> are clearly established.

**Potency:** Potency of this U.S.P. product is accurately determined by precise weight.

**Purity:** Pure anti-anemia factor.

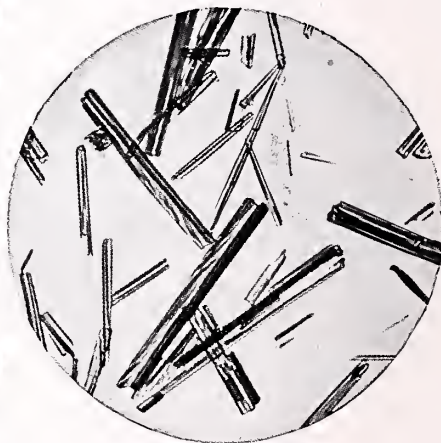
**Efficacy:** Produces, in microgram dosage, maximum hematologic and neurologic effects.

**Tolerance:** Extremely well tolerated; "no evidence of sensitivity" has been reported.

## Toxicity Studies:

In recent pharmacologic investigations, extremely large doses of *crystalline* vitamin B<sub>12</sub> (1,600 mg./Kg.) caused no toxic reactions in any of the animals treated. In contrast, 3 mg./Kg. of a "concentrate" caused fatal reactions in 100 per cent of the animals treated.

Merck—first to isolate and produce vitamin B<sub>12</sub>—supplies Crystalline Vitamin B<sub>12</sub> in saline solution under the trademark Cobione.\* Your pharmacist stocks Cobione in 1 cc. ampuls containing 15 micrograms of crystalline vitamin B<sub>12</sub>.



*Crystalline Vitamin B<sub>12</sub>*

\* Cobione is the registered trade-mark of Merck & Co., Inc. for its brand of Crystalline Vitamin B<sub>12</sub>.

# B<sub>12</sub> COBIONE®

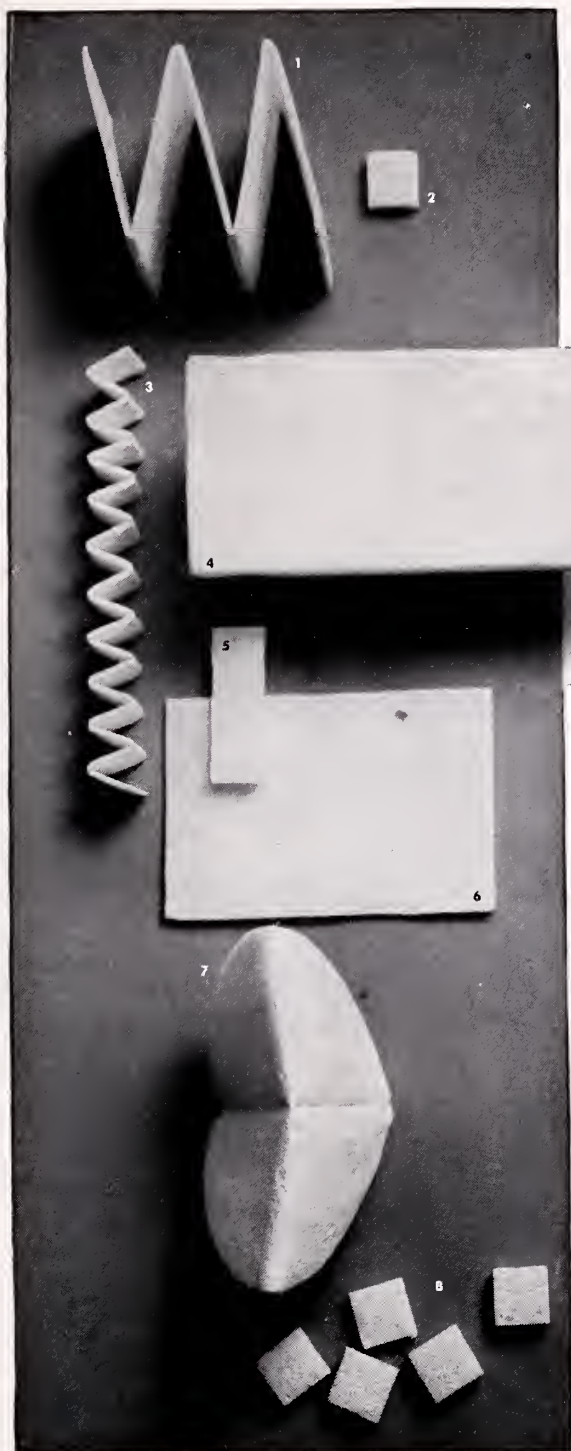
*Crystalline Vitamin B<sub>12</sub> Merck*



**MERCK & CO., INC.**  
*Manufacturing Chemists*  
RAHWAY, NEW JERSEY

New York, N. Y. • Philadelphia, Pa. • St. Louis, Mo. • Chicago, Ill. • Elkton, Va. • Danville, Pa. • Los Angeles, Calif.  
In Canada: MERCK & CO. Limited. Montreal • Toronto • Valleyfield





## ***foamed and formed . . .***

Gelfoam,\* the new hemostatic agent invented and developed by Upjohn research workers, is prepared from a specially treated gelatin, foamed and formed into a number of clinically convenient shapes and sizes—as a pack (1,3), a swab for Gladstone sponge biopsy (2), a sponge to be cut to any desired shape or size (4,5,6), prostatectomy cone (7), and dental packs (8). This absorbable gelatin sponge affords the opportunity for better hemostasis in the various fields of medicine and surgery.

*\*Trademark, Reg. U. S. Pat. Off.*

# **Upjohn**

***Medicine . . . Produced with care . . . Designed for health***

THE UPJOHN COMPANY, KALAMAZOO 99, MICHIGAN

## *A urinary tract infection*

resistant to "...all available antibiotics and  
chemotherapeutic agents..."

TREATED WITH TERRAMYCIN

M. F., male, age 48

**P.H.:** Pyelonephritis of 1½ years' duration following uretero-cutaneous implants (mixed infection); previous therapy with all available antibiotics and chemotherapeutic agents without response.

**Lab. data:** Urinary cultures positive for *P. vulgaris*, *E. coli*. Staph. albus and enterococci.

**Therapy:** Terramycin 2 Gm. daily for five days; orally in divided doses q. 6 h.

**Result:** Urine cultures negative except for *P. vulgaris* by 2nd day of treatment. Response described as "good".

Case report abstracted from: King, E. Q. et al.: J.A.M.A. 143:1 (May 6) 1950.

CRYSTALLINE  
**Terramycin**

### *suggested for:*

acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to *E. coli*, *A. aerogenes*, *Staphylococcus albus* or *aureus*, and other Terramycin-sensitive organisms; acute brucellosis (*abortus melitensis*, *suis*); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsialpox.



**NEW Council-accepted  
broad-spectrum antibiotic  
orally effective—well tolerated**



1. Terramycin may be highly effective even when other antibiotics fail.<sup>1</sup>
2. Terramycin may be well tolerated even when other antibiotics are not.<sup>2</sup>

# mycin

HYDROCHLORIDE

**Dosage:** On the basis of findings obtained at over 150 leading medical research centers, 2 Gm. daily by mouth in divided doses q. 6 h. is suggested for acute infections.

**Supplied:** 250 mg. capsules, bottles of 16 and 100;  
100 mg. capsules, bottles of 25 and 100;  
50 mg. capsules, bottles of 25 and 100.

1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: J.A.M.A. 143:1 (May 6) 1950.
2. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meets. Mayo Clin. 25:183 (Apr. 12) 1950.

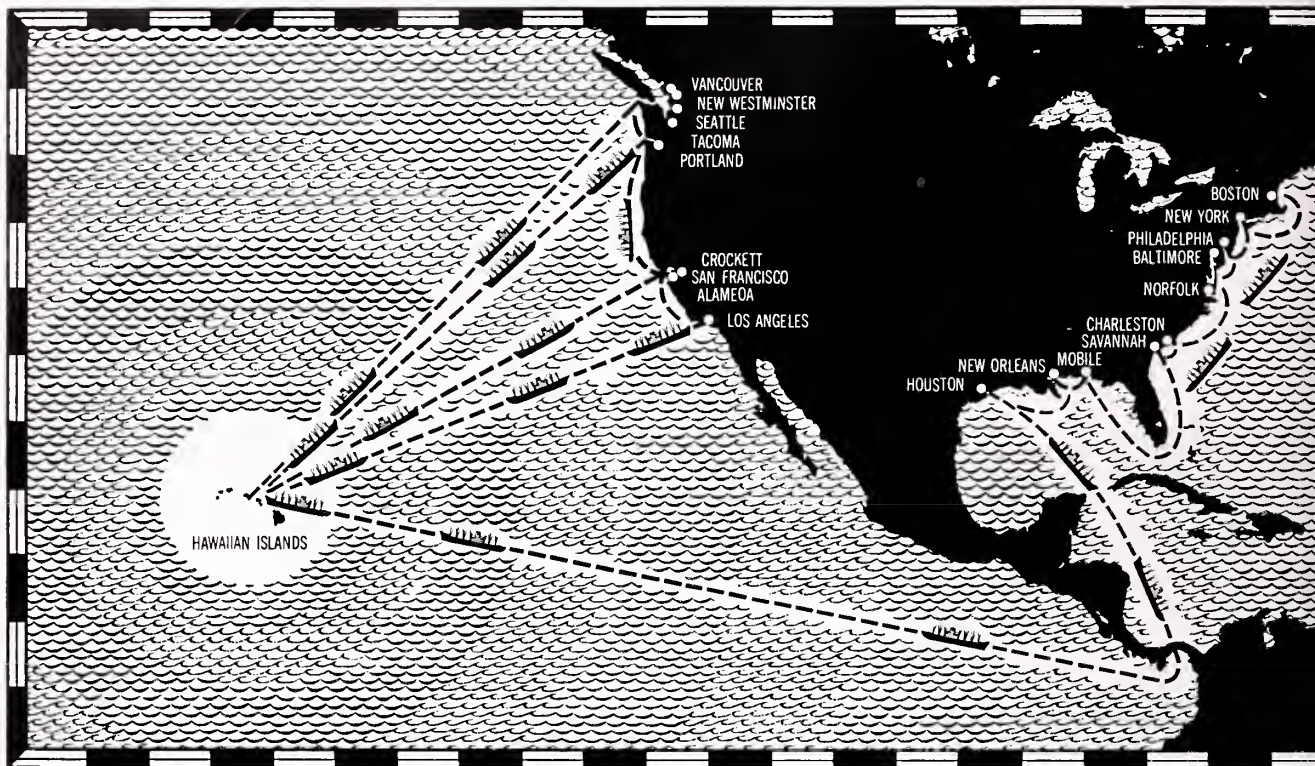
**Pfizer**

**Antibiotic Division**

CHAS. PFIZER & CO., INC., Brooklyn 6, N.Y.



# Matson freight service is made to order for Hawaii



One glance at this map shows you the widespread freight service provided by Matson for Hawaii. It connects the islands with every

major mainland port. And the routes shown are the routes Matson freighters always follow. They are never diverted to any other trade.

Week in and week out these ships operate on regular schedules. They provide a weekly sailing from San Francisco and Los Angeles . . . a sailing every two weeks from the Pacific Northwest . . . a sailing every ten days from Gulf and Atlantic ports (operating in conjunction with the Isthmian Line). Their speed is an outstanding feature. They make the run from California in 5½ days, with corresponding speed on other routes.

This fast, frequent, regular service is of immense advantage to all merchants in the islands. They know to the day when the goods they have ordered from the mainland will reach port. With sailings so frequent and fast, they can carry smaller stocks of goods and cut down their operating cost. It enables them to buy to the best advantage and meet any sudden demand.

The advantages of Matson service are shared by the entire public. It assures them direct, economical transportation for the goods they require from every major mainland source of supply. There is no service more vital to an island community than the lifeline of overseas shipping. Hawaii has it in its most modern, efficient and dependable form.



## Matson Lines

*This is one of a series of messages giving interesting facts about one of Hawaii's most vital activities...overseas transportation.*

*Dispersible*  
**DRISDOL®**  
 WITH  
**VITAMIN A**

COMPLETELY  
*Milk*  
*Diffusible*



a+d

Drisdol with Vitamin A administered in milk becomes an integral part of the child's diet. It diffuses completely in milk, orange juice and other liquids without an oily film, does not separate, float or tend to adhere to nursing bottle or nipple. May also be given on the tongue or in solid foods.

Drisdol with Vitamin A contains per gram 50,000 units of vitamin A and 10,000 units of crystalline vitamin D<sub>2</sub> (calciferol). Each drop delivers 1250 vitamin A units and 250 vitamin D units.

**Dosage** for infants, 2 drops; for older children and adults, from 4 to 6 drops daily in milk.

Supplied in bottles of 10 cc. and 50 cc. with dropper.

Also Drisdol in Propylene Glycol (10,000 units of vitamin D<sub>2</sub> per gram) in bottles of 5 cc., 10 cc. and 50 cc.



*To help build a sound structure and promote growth*

Drisdol, trademark reg. U. S. & Canada,  
 brand of crystalline vitamin D<sub>2</sub> (calciferol)

*Winthrop-Stearns* INC.  
 NEW YORK, N. Y. WINDSOR, ONT.

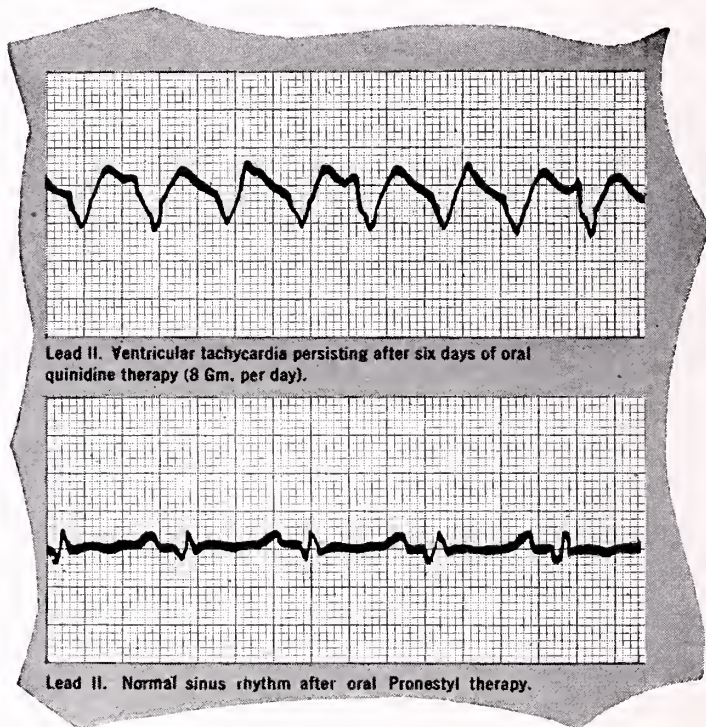


a **new** drug . . .

*for the treatment of ventricular arrhythmias*

# PRONESTYL *Hydrochloride*

*Squibb Procaine Amide Hydrochloride*



Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evidenced by studies of blood count, urine, liver function, blood pressure, and electrocardiogram. Pronestyl may be given intravenously with relative safety.

PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.  
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

*For detailed information on dosage and administration, write for literature or ask your Squibb Professional Service Representative.*

**SQUIBB** MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.



# HAWAII MEDICAL JOURNAL

and

## INTER-ISLAND NURSES' BULLETIN

Volume 10  
Number 2

NOVEMBER-DECEMBER, 1950

\$2.00 per Year  
35c per Copy

Published Bi-Monthly by

THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

### THE HAWAII TERRITORIAL MEDICAL ASSOCIATION 1950-1951 OFFICERS

R. L. HILL, Honolulu.....	President
H. L. ARNOLD, JR., Honolulu.....	President-Elect
LEO BERNSTEIN, Hilo.....	Vice-President from Hawaii County
S. L. YEE, Honolulu.....	Vice-President from Honolulu County
WILLIAM GOODHUE, Eleele.....	Vice-President from Kauai County
R. F. COLE, Paia.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

### COMMITTEE CHAIRMEN

GROVER A. BATTEN.....	{ Cancer Committee Resolutions Committee
SAMUEL D. ALLISON.....	Health Education Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	HAWAII MEDICAL JOURNAL
WILLIAM H. STEVENS.....	Committee on Psychiatry and Neurology
SAMUEL L. YEE.....	By-Laws Committee
THOMAS H. RICHERT.....	Advisory Board for Woman's Auxiliary
RICHARD C. DURANT.....	Public Service Committee
HARRY L. ARNOLD, JR.....	Committee on Public Policy and Legislation
LAURENCE M. WIIG.....	Scientific Works Committee
VERNE C. WAITE.....	Postgraduate Committee
ROBERT D. MILLARD.....	Fee Schedule Committee

### OFFICERS—COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....L. Bernstein, Hilo	S. L. Yee	W. Goodhue, Eleele	R. F. Cole, Paia
<i>Vice-President</i> .....T. D. Woo, Pepekeo	J. W. Devereux	K. K. Fujii, Kapaa	E. Kushi, Wailuku
<i>Secretary</i> .....P. Okumoto, Hilo	W. Walsh	K. Kuhlman, Koloa	E. T. Shimokawa, Lahaina
<i>Treasurer</i> .....M. L. Chang, Hilo	W. Ito	K. Kuhlman, Koloa	E. T. Shimokawa, Lahaina

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1950, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second-class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.

## A Firm Foundation for a Sound Future

The first few months of life are of critical importance in building a healthy foundation for the infant. It is during this period that the demands for protein to create new tissue are greatest. And it is at this time that infants must have a food which supplies, in addition to adequate protein, other elements needed for sound growth. DRYCO feedings (with added carbohydrate) closely approximate the nutritional and digestive characteristics of human milk.

The DRYCO formula, in addition to a high-protein content, offers a reduced fat level. With added carbohydrate, DRYCO feedings assure sufficient caloric intake for normal requirements, while at the same time minimizing digestive disturbances.

Additional advantages of DRYCO are adequate vitamin and mineral potencies, moderate carbohydrate to provide formula flexibility, uniformity and bacteriological safety, as well as ease of preparation for the mother.



VITAMIN  
FORTIFIED

# DRYCO

*Detailed professional data, together with feeding tables may be obtained simply by writing to:*

**THE BORDEN COMPANY, Export Division**  
350 Madison Avenue, New York 17, N. Y., U. S. A.

# PUBLIC HEALTH IN HAWAII, 1950

IRA V. HISCOCK, M.P.H., Sc.D.\*

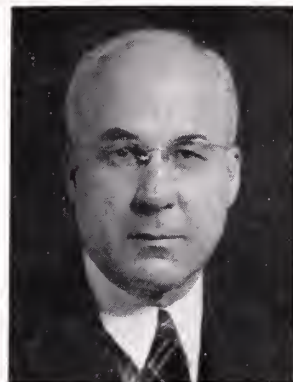
NEW HAVEN, CONN.

THIS study of the organization and administration of the public health services in the Territory of Hawaii has been conducted under the auspices of the Oahu Health Council, with the assistance of the Department of Health and of other official and voluntary agencies concerned actively with public health, including the medical and dental societies. The objective was three-fold: to appraise the problems and resources; to confer with many representative officials, executives, board members and taxpayers; and to help in outlining plans for the future.

Information was obtained from numerous reports of special studies conducted under the auspices of the Chamber of Commerce,<sup>1</sup> and by the local section of the American Academy of Pediatrics, and by the Board of Health, among others. The study was conducted chiefly by interviews and conferences, by visits to the departments and organizations concerned, and by reviews of reports, records and laws. Data recorded on the Evaluation Schedule of the American Public Health Association were compared on Health Practice Indices<sup>2</sup> with similar data from over 200 mainland counties and local health units. Similar appraisals have been carried out for years by the Board of Health. Attention was given to progress made during the past two decades, and considerable time was spent in a scrutiny of the application of the programs in local communities on each island.

Excellent cooperation was received from the representatives of governmental departments studied, and from hundreds of individuals and voluntary agencies on the Islands of Hawaii, Kauai, Maui, Molokai, and Oahu, including the President of the Board of Health, who accompanied the writer in visits to the islands. Valuable assistance was rendered by the executive secretary

and officers and board members of the Oahu Health Council in the arrangement of schedules, the distribution of questionnaires<sup>3</sup> and otherwise. Each island had a special advisory committee. Time and viewpoints were given generously and objectively by those interviewed throughout the Territory during the seven weeks of intensive study following several months of local work. Grateful appreciation is expressed for this invaluable assistance and for the gracious hospitality received everywhere.†



DR. HISCOCK

## I. Introduction

This study disclosed marked progress in the development of public health organization and services and dramatic results from these programs during the past twenty years. Hawaii is blessed with many natural resources which enrich the life of her people; but the modern comforts and scientific benefits so abundantly provided are the results of vision, energy and careful planning of community leaders. The continued achievements in the promotion of health and the reduction of preventable diseases indicate foresight, judgment, loyalty

\* On file in the office of the Oahu Health Council.

† Survey Advisory Committee: F. J. Pinkerton, M.D., Chairman, Harry L. Arnold, Jr., M.D., Morton Berk, M.D., Margaret M. L. Catton, Charles F. Chillingworth, Mrs. Randolph Crossley, Arthur L. Dean, Mrs. John W. Devereux, Laura Draper, J. Ernest Ednie, Hubert Everly, Carl Flath, Morris G. Fox, Richard F. Guard, Marcus Guensberg, M.D., Mrs. Margaret Hackfield, Peyton Harrison, Brigadier General Silas B. Hays, Mrs. Wm. Janney Hull, Jan Jabulka, Colonel Harold W. Kent, Carolyn Kingdon, Edmund Lee, M.D., R. K. C. Lee, M.D., John C. Linczer, Edward Loftus, Oren E. Long, Harry Mau, Mary McCarthy, Mrs. L. Q. McComas, Kathleen McDuffie, Calvin C. McGregor, Frank Midkiff, Slator Miller, Colonel James Moore, Eldon P. Morrell, Walter M. Murai, Mabelclaire Norman, Mrs. Lloyd B. Osborne, H. M. Patterson, M.D., Captain Wendell H. Perry, Lyle Phillips, M.D., Theodore Rhea, Mrs. Herbert Richards, W. Tate Robinson, Robert Sample, D.D.S., Gregg M. Sinclair, Shigeo Soga, Horace Taba, Dwight Uyeno, D.D.S., Hastings Walker, M.D., A. L. Y. Ward, C. L. Wilbar, Jr., M.D., Elbert Yee.

\* Chairman, Dept. of Public Health, Yale University.

<sup>1</sup> Of special significance and value are "Planning for Health" and pamphlets, special reports and volumes listed, together with the Recommendations of the Postwar Planning Committees on Health, Public Health Committee, Chamber of Commerce of Honolulu, Hawaii, 1948. On file in the office of the Oahu Health Council.

<sup>2</sup> On file in the Department of Health, T. H.



and skill, with human benefits and significance comparable to the most advanced communities and states on the mainland. At the same time a generally apparent attitude of constructive self-criticism, coupled with the application of searching appraisal methods, gives promise of continuing advances in the health program of Hawaii in line with new scientific advances and tested procedures.

This survey revealed strong and weak features in governmental and private agency resources in Hawaii, besides emphasizing the importance of guiding principles mentioned later in the report which may be useful in the future. With extensive reports and documents readily available for reference and study, unlike the practice in most surveys, special efforts were made to confer with many people associated with the health program of the Territory and to observe activities briefly. This report deals primarily with organization and future opportunities, and contains only such statistical and detailed descriptive material as may be essential for background purposes. Emphasis should be given to the value of these earlier studies and recommendations of the Postwar Planning Committees. Few if any states have had the benefit of as many careful studies of functional needs and activities in which also many citizens, professional and lay, have participated. Few states have as good a framework for the operation of voluntary health agencies found by study to be essential, and for health councils.

In a meeting of Board members and executives of health agencies held during the course of the survey,<sup>4</sup> Mr. Slator Miller, member of the Survey Advisory Committee and Board Member of the Oahu Health Council, called attention to the primary objective of the World Health Organization as "the attainment by all peoples of the highest possible level of health," and to the definition of health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." Health implies satisfaction in living, not merely keeping out of the hospital or sanatorium, the compensation records, or the death certificates!

A definition of public health has been given by C.-E. A. Winslow, Editor of the *American Journal of Public Health* and long-time member of the Connecticut State Public Health Council:

Public Health is the science and art of preventing disease, prolonging life and promoting physical and mental health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing

services for the early diagnosis and preventive treatment of disease and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.

This study embraces a consideration of public health personnel, organization and expenditures; general natality and mortality; communicable diseases, including tuberculosis and venereal diseases; maternal and child health; adult health; public health nursing; sanitation and safety of the environment including accidents, water supplies and excreta disposal, food control and milk control; health education and health councils. It does not cover details of hospital management and practices, medical care administration, housing construction and welfare, each one of which presents related major problems which have been studied by other observers and groups.

A health survey of Honolulu was made in 1929 under the auspices of the United Welfare Fund. The report contained some one hundred recommendations pertaining strictly to public health, besides several relating to welfare, which were proposed on the basis of group consideration of needs. All of those recommendations, except for a few details not applicable, have been carried out, and basic provisions have been supplemented and new activities developed. The survey of 1935, under the auspices of the Honolulu Chamber of Commerce, with the cooperation of groups on the other islands, carried six basic and comprehensive recommendations. These proposals have been carried out also, with a few exceptions, such as the urgent need still existing for proper qualifications for the chief executive of the Territorial Department of Health, for a trained and experienced health officer on Maui (for which provision was made recently), and for an adequate increase in public health nurses (especially in Honolulu). In addition, many recommendations of the Postwar Planning Committee, published in summary form in 1948, have been carried out.

Among the strong factors, or assets, in Hawaii are the following:

1. Increasing public interest in health individually and in groups, and with leadership displayed among board members of health, medical, dental and nursing agencies, by plantation management, by chambers of commerce, service clubs, parent-teacher associations, and women's clubs among other groups.

2. High standards of medical and dental practice, and improving general, mental and tuberculosis hospital resources, and provisions for treatment of Hansen's disease, with new construction and improved methods for hospital and medical care, and regionalization trends for general hospitals, besides a well-equipped convalescent nursing home in Honolulu. A valuable Shriner's

<sup>4</sup> Mabel Smyth Auditorium, Thursday evening, August 17, 1950

Hospital. Unusually well organized and administered Blood Bank.

3. Contribution for many years of plantation health services.

4. Good communication facilities.

5. Relatively favorable economic status, and financial ability to secure this often purchasable commodity, health.

6. A Territorial Department of Health which compares favorably with that of most states on the mainland in basic structure and in qualifications of the incumbent Chief and Assistant Chief Executives and of the division and bureau heads, and with full-time medical health officers on Hawaii and Kauai and provisions for the same on Maui.

7. Good water supply and provisions for extension of sewage disposal in Honolulu, and modern plumbing recently secured for all rural schools on Kauai and Maui. Milk supply pasteurized 100 per cent on Kauai and Oahu and increasing on Maui and Hawaii. An effective plague control program. Absence of malaria-bearing mosquitoes and maintenance of low index of dengue-bearing mosquitoes.

8. Reduction in all communicable diseases, with low incidence of cases and deaths of diphtheria, typhoid fever and typhus fever, with no cases of smallpox for thirty-seven years, and no human or animal rabies. A comprehensive immunization program including measures against diphtheria, smallpox, typhoid, tetanus, and whooping cough. Relatively low incidence of syphilis and gonorrhea, and good control of prostitution. Well organized and directed public health laboratory services.

9. Effective tuberculosis control program, official and voluntary, including widespread mass chest x-rays, modern surgical and other treatment, increasing provisions for rehabilitation and social service, routine x-ray of hospital admissions in the Wilcox Memorial Hospital on Kauai and 90 per cent in the second hospital of the island, and a new administrative research and appraisal project.

10. One of the most effective programs for maternal and child health, including crippled children programs (official and voluntary), in the United States, with a low death rate from diseases of infancy and maternity and a high hospital delivery rate (96 per cent). Medical examinations of all children entering school compulsory by law.

11. Generalized public health nursing program, ably directed. Plans for improvement of nursing education in cooperation with the University of Hawaii.

12. Essential voluntary health agencies, including cancer, crippled children and adults, dental clinic for children (Strong-Carter), heart, infantile paralysis, mental hygiene, and tuberculosis, besides other professional and lay organizations to assist in such endeavors as the conservation of hearing and vision and in health education.

13. Active Oahu Health Council.

14. Active Public Health Committees of Chambers of Commerce.

15. Great devotion to duty, and loyalty on the part of members of the staffs, both professional, clerical and secretarial, and of boards and trustees of health agencies.

16. Well planned Civil Defense Program.

17. Health regulations covering essential elements of public health practices, revised periodically.

Weaker features of the health programs, or liabilities:

1. Complex housing problems for both official and voluntary health agencies, which are crowded and scattered, with long distances between official bureaus, unhealthful quarters for some personnel as to physical and lighting and crowded conditions, with vital records stored in basements instead of in fire-proof vaults, with urgent need for cooperative plans on all islands whereby joint housing of appropriate groups would conserve travel time and facilitate team work and increase efficiency.

2. Cumbersome civil service and budgetary requirements and operation, very expensive in delays and restrictions in securing qualified personnel in the midst of unattained objectives and unfulfilled ambitions in essential mental health and public health services.

3. Personnel shortages, lack of understudies and deputies, as in records and statistics, and other problems related to salaries, top to bottom, to classifications and qualification provisions.

4. Gaps in services for dental health (both for adults and children), mental health, nutrition, physical medicine, and social services, and in community health education resources. There are also gaps in home nursing and care of the sick in their homes, with accompanying inadequate provisions for trained practical nurses and for visiting housekeeper service—a problem which is likely to increase as the burdens of chronic illness grow larger.

5. Complex water supply and sewage disposal problems in some communities, especially on Hawaii, Maui and Kauai.

6. Lack of awareness and understanding by some officials and by many other taxpayers, of the organization, purposes and low cost of a modern practical community health program.

7. Problems of transportation of people to health conferences and clinics, especially in rural areas.

8. Lack of organized volunteer services except for a beginning in Honolulu.

9. Inadequate resources for adult mental hygiene intimately related to other public health resources, in contrast with the essential service (primarily in behalf of children and for prevention of juvenile delinquency) of the Department of Health, and the progressive treatment services of the Department of Institutions.

10. Gaps in provisions for conservation of hearing and of vision.

11. Inadequate utilization or development of measures to carry out provisions of plan and School Health Policies prepared jointly by the Departments of Health and of Public Instruction in 1941.

12. Many problems, including medical and dental, with inequities in hospital reimbursements, concerned with care of the medically indigent.

13. Inadequate number of selected Territorial resident men and women in training (possibly on fellowships) for important positions in public health.

14. Incomplete coordination of essential health services, with lack of health councils on Kauai and Maui, and only partial coverage of essential groups on Hawaii.

## II. Major Proposals for Long Term Development

The following proposals are offered for consideration in a long term plan of action (e.g. five to ten years) involving only a relatively small new financial outlay, in view of problems which present knowledge renders vulnerable to attack:



1. That necessary changes be made in organization procedure and legislation whereby the Board of Health of the Territory will become more completely a citizen advisory and consultative body, except for:

- a. formulation of the public health regulations;
- b. prescription of qualifications of personnel (positions, not individuals);
- c. approval of budget submitted to higher authority; and
- d. advice on policies.

This would leave the administrative control and executive responsibilities for the Chief Executive Officer (President of the Board of Health).

2. That the following recommendations of the Postwar Planning Committees on Health, as published by the Public Health Committee of the Chamber of Commerce of Honolulu, 1948, receive immediate attention toward appropriate action, including the writer's supplementary proposals in parentheses:

a. That Section 2011 (R.L.H. 1945) defining powers and duties of health personnel, should be amended to require the President of the Board of Health (Executive Officer) to be a licensed physician (or eligible to secure a license) of the Territory and to have other appropriate and specific qualifications for public health administration (in line with recommendations of the State and Territorial Health Officers and of the Professional Education Committee of the American Public Health Association).

b. That a school health section should be established in the Maternal and Child Health Bureau (and that adequate funds be provided to carry out the provisions of paragraphs 3-7 of the recommendations adopted in the committee report cited, page 18, including necessary funds for the Chief of Preventive Medicine, and also for the positions of Chiefs of Hospital and Medical Care and of Dental Health—not listed—and of Local Health Services, with specific reference to supervision of the operating program in the City and County of Honolulu, par. 10).

c. That the Legislature should provide for more flexibility in the departmental appropriation and budget operation for the Department of Health, allowing timely reallocations by the Department of Health to its various uses according to its best judgment (par. 15).

d. That the Department of Health, as a matter of urgency, should be provided with a new building in Honolulu, which would include a new health center, and that the Department of Health facilities at Hilo, Wailuku and Lihue, now inadequate and otherwise unsatisfactory, especially at

Lihue, should be expanded and improved.

e. That the medical care program, now divided among the Department of Health, the Department of Public Welfare and the county governments, be made less cumbersome in its operation. Since the Advisory Committee to the Subcommittee on Hospitals, Medical Care, Health and Welfare of the Territorial Holdover Committee has been studying this particular subject for over a year, full support should be given to all constructive recommendations made by this group at the next legislative session. Community groups and individuals interested in this subject should closely follow the work of the Advisory Committee in their deliberations and actions.

f. That an individual eminently qualified in school health should be employed as administrator of the program in the Department of Public Instruction (p. 31) (preferably in the grade of deputy superintendent and working jointly with the Department of Health, which should be equipped with and responsible for an effective school health service unit as outlined in the report cited, par. 3, p. 31).

g. That implementation be given to the recommendations for immediate action as related to medical examinations and correction of health defects (pars. 6-23, p. 32-33) (in line also with the School Health Policy, published by the joint committee of the Departments of Health and of Public Instruction in 1941).

h. That implementation be given to the recommendations previously made concerning the formation of school health councils, adequate space in schools for health work, in-service and teacher training.

i. That a central school of nursing should be instituted at the University of Hawaii (with adequate personnel and budget). (See Recommendations 2 and 9, p. 42, Hospital Costs in Hawaii, Public Health Committee, Chamber of Commerce, August, 1949.)

j. That the Bureau of Health Statistics be expanded in the Department of Health (and more widely utilized by all appropriate official and voluntary agencies concerned with health, some of whom now derive much help from this source) as promptly as funds and qualified personnel can be obtained. (Of special urgency is the appointment of a trained deputy chief of statistics.)

3. That early steps be taken by proper authorities to correct the cumbersome civil service and budgetary requirements and operation, to overhaul civil service classifications for professional positions, including nursing, and otherwise im-



prove existing unsatisfactory procedures which are so expensive in delays and restrictions in securing and holding qualified personnel in essential public health services.

4. That early steps be taken to adjust inequities in salaries of health personnel in line with recognized duties and responsibilities and with other salaries paid and professional incomes in the Territory and on the mainland, including the salaries of the Chief Executive in Public Health to at least \$15,000, the Assistant Health Executive, and certain medical and non-medical bureau chiefs and certain staff members.

5. That increased efforts be made to fill vacancies and important new positions in official and voluntary health agencies throughout the Territory by the development of committees on personnel and training by the Oahu Health Council and by health councils to be formed on each of the other islands, such committees to be charged with duties including the following:

a. The securing of funds from agencies and foundations for pooled scholarship budgets to provide for trained personnel and personnel reserves throughout Hawaii.

b. The collection and dissemination of information to high school and university students concerning opportunities for careers in public health.

c. The recruitment of residents of Hawaii for graduate training and for travel fellowships for gaining education and experience in Hawaii and on the mainland.

d. The arrangement for exchange of personnel with other health groups as provided by legislation now existing.

6. That the program of the Oahu Health Council be supported adequately on a long-term basis. Exclusive of rent and travel, a minimum budget of \$20,000 annually will be necessary, exclusive of special grants needed for projects which might be undertaken outside of routine activities if and when group judgment indicates such action. It is easily recognized that member agencies will be unable to meet the total financial needs of the Council. Continued support of this valuable program by the Chamber of Commerce and by foundations is strongly recommended.

7. That community leaders in Kauai and Maui expedite the formation of local health councils and that the Advisory Health Council to the health officer in Hawaii be expanded in representation and scope of activity or a community health council formed on Hawaii also, all with objectives similar to those adopted by the Oahu Health Council. Representatives of each local health coun-

cil might profitably form the nucleus of a health council of the Territory of Hawaii constituted to deal with projects of importance for the whole Territory. Such councils are in line with proposals by the American Medical Association, the American Public Health Association, the American Hospital Association, the National Congress of Parents and Teachers, the General Federation of Women's Clubs, the National Voluntary Health Agencies and the National Health Council. Emphasis should be given to the fact that the health council is a composite of its membership, organized to serve the community and its members on matters of mutual concern; and it can thus be as strong and helpful as is provided by the membership participation.

8. That there be appointed on Hawaii, Kauai and Maui, under a joint management plan, a community health educator for each island, equipped with proper clerical help and transportation, in order to ensure, among other things, better coordination and public understanding of services, and full utilization of the voluntary and official agencies in the development of a community health program, and to eliminate duplication of services. The voluntary health agencies of the islands might unite in securing for each island (Hawaii, Kauai, Maui) through a pooled budget, a qualified worker in community health education and community health organization. Such a step seems practical prior to the appointment of a full-time worker for a special interest field by any agency. A part of the health department's immediate contribution "in kind" might be office space and some secretarial assistance.

9. That special temporary subcommittees of the Oahu Health Council be formed to study further and give impetus to measures for filling serious gaps in Honolulu and in the other counties of Hawaii in measures and personnel to improve dental health, health education, geriatrics, mental health (including services for persons above the medically indigent class), nutrition, nursing education, rehabilitation and social services. With pressing problems of regionalization of hospitals, in relation to community affairs, there is urgency also in having many factors considered on a group planning basis over and above the extensive studies and discussion of financial problems which occupy much of the attention of the hospital administrators in conference in the so-called Hospital Council of Honolulu. Huge sums of money, continuing problems of hundreds of thousands of people, complex questions of industrial management and labor, are among the reasons for giving active attention to the subject.

10. That efforts be continued for the timely arrangement of professional education, programs for physicians, dentists, nurses, hospital personnel and others who care for expectant mothers and fathers and their children, and for utilization of data on morbidity, handicapping defects and mortality by these groups for teaching purposes, besides expansion in systems of reporting and circulating of health statistics for use by strategic groups concerned with these and related problems. In view of the apparently high incidence of premature births in the Territory, consideration should be given to possibilities for increased preventive activities, professional and lay education, including studies of the specific aspects of the problem more fully statistically and clinically. Likewise there is opportunity, with the cooperation of the professional associations, the hospital staffs and trustees, the University of Hawaii, and the Oahu Health Council and its member agencies to render valuable services in joint health and educational conferences and institutes, of varying lengths, for Hawaii and the Pacific area.

11. That to increase economy, efficiency and team work, the Oahu Health Council and the voluntary health agencies in Honolulu continue vigorous efforts to provide for the housing of as many health agencies as possible in a community health agency center, all under one roof, reasonably accessible for board and committee members, and for the other official agencies, educational and social agencies with whom they work. This might be in the vicinity of or attached to the Mabel Smyth Memorial Building. Similar joint housing needs exist on the other islands, where, as on Maui, it is desirable to explore carefully the possibilities for the location of official and voluntary health agencies in close proximity to the community hospital.

12. That additional study be given (with a view to the preparation of plans) to the possibilities explored briefly by the Public Health Committee of the Chamber of Commerce for a comprehensive Community Health Education Center including and developed around the dynamic focus of a Health Museum of Hawaii. Such a center could be a lively service unit for all health agencies, hospitals, schools and colleges and professional and lay groups throughout the Territory of Hawaii, besides providing an outstanding center for audio-visual projects, individual and group instruction and interpretation, and other purposes. Such a center could be an important instrument for the achievement of the practical objective for Hawaii as the Paradise for Health—a goal almost realized in comparison with other communities in 1950.

13. That the voluntary health agencies, an essential part of the community health programs of each island and of the Territory as a whole, review their organization and programs with reference to the following:

a. Extent of participation of officers, board and committee members in policy formation and long-term planning.

b. Provision of written administrative and professional policies well understood within the agency and among cooperating groups.

c. Needs for increased community health education services.

d. Opportunities to use health statistics of the Department of Health more fully for guiding administrative plans.

e. Values to be gained from joint housing with other health agencies.

f. Effectiveness of working relationships with other voluntary and official health agencies.

g. Possibilities of cooperating with other community agencies in the development of a fellowship pool for training of necessary personnel selected from residents of Hawaii, and participating in a cooperative plan for the employment of a community health education worker or other urgently needed personnel.

h. Opportunities for increased team work with other agencies in the provision of case finding, education and follow up.

14. That restorative dental services for elementary school children be stabilized near a level to be determined by a public health committee of the dental profession in association with the President of the Board of Health; and the current neglect of the permanent teeth of high school children be corrected. Trained personnel should be provided as needed for the topical application of sodium fluoride to the teeth of children, in line with the experience of the U.S.P.H.S. and other authorities. Attention should be given to preventive measures, and surveys of caries prevalence should be carried on to measure progress of the dental program. A pilot study of the artificial fluoridation of a water supply for a community might be undertaken.

15. That nutrition services should be expanded, with such nutrition service assisted by a nutrition advisory committee affiliated with a local health council. The nutrition service should be a part of the program of the health department; consultant service should be emphasized and direct service by nutritionists maintained at a minimum. Means for dietary analysis are also needed.

16. That community chest and other private support for the Mental Hygiene Society of Hawaii be continued, and raised to a higher level; that



more accessible and extensive mental health outpatient clinics and agency consulting facilities be provided for both adults and children, the latter so placed that services are integrated with the child's daily educational and recreational life; that increased attention be given to gaps in child guidance services; and that the services of the Psychological Clinic be reallocated in a manner to meet the community needs more fully. While the Psychological Clinic has rendered valuable and essential services, its continuance as a separate unit is questioned; consideration should be given to reorganization in a manner to strengthen at the same time the meager psychological services of the Department of Health and of the Mental Hospital.

17. That continuing attention be given to the feasibility of merger of laundry and other facilities among selected hospitals in communities in the Territory and to coordination of other service departments where an increase of efficiency may be obtained; that hospitals bill their full rates to all paying agencies, indicating, where necessary, the allowance which is made to meet the difference between cost and payment; that efforts be continued to achieve uniformity of payment for welfare patients and for the development of a standard method of determining eligibility, and the basic budgets and policies as outlined, as a guide, by the American Public Welfare Association; that increased provision be made for social workers in general, mental and tuberculosis hospitals; and that standard accounting procedures as outlined in the *Manual on Hospital Accounting* issued by the American Hospital Association in 1949 be developed as a central project by the Hospital Association of Hawaii. Continuing review and periodic studies of special hospital problems related to community needs and to hospital costs in relation to services and to income, are among subjects which will require committee actions from time to time under the auspices of the Health Council.

18. That the justification for a separate emergency medical and surgical unit be reconsidered, with a view to more efficient long-term plans and in light of experience in many localities on the mainland which indicates the desirability of having emergency rooms in the general hospital. Hospitals that qualify will need to be repaid on a reimbursable cost basis, or on an open contract plan.<sup>5</sup>

19. That a geriatrics unit be established in the Department of Health's Division of Preventive

Medicine, in view of preventive techniques being successfully applied to heart disease, diabetes, glaucoma, and other conditions related to adult health, and to efforts to achieve early diagnosis and appropriate therapy and to minimize the effects of these diseases at a time when the shifting age distribution of the population is a factor in program planning for a public health program during the next decade. The cooperation of the voluntary agencies, including the Hawaii Cancer Society and the Heart Association of Hawaii, is essential and is effective.

20. That, in considering future plans of organization relating to natural resources and sanitation of the environment, due recognition be given to the functional and legal responsibilities of the Territorial Department of Health for the safeguarding of food supplies, for the protection of bathing places, and for the prevention of health nuisances and hazards from sewage disposal and other household, hospital and industrial wastes which may be related to water pollution.

21. That, as rapidly as possible, the salaries for essential key personnel of the Department of Health now carried by Federal funds be assumed in the regular budget of the Territory. It should be borne in mind that the official expenditures for public health by the Territory, represented by less than 5 per cent of all Territorial appropriations for the biennium 1949-51, for example, are comparable with the amounts which come from local city and county and state sources on the mainland.

22. That the resources for health services at the University of Hawaii be expanded with special reference at the outset to increased provisions for nursing education, for health education including joint institutes and conferences for professional health and educational groups, and for student health services.

23. That the policies of the Board of Health with respect to case finding and control measures and follow-up to meet the unusually complex health, economic and social problems of Hansen's disease be supported.

24. That medical and public health measures for conservation of vision be a responsibility of the Department of Health, while duties of an educational nature primarily be assigned to the Department of Public Instruction, the budget and personnel provisions of the separate Territorial Bureau being distributed accordingly, with necessary provision made for such important steps in the next legislature. There is likewise urgent need for a constructive program for the conservation of hearing, properly coordinated with the services for crippled children of the Department of Health.

<sup>5</sup> In some cities the Police Department operates ambulances; in others, the fire department operates the emergency ambulances, while others depend upon private services or upon hospitals. The chief objections which hospitals have to operating ambulances are related to expense, to the difficulty of keeping sufficient drivers and attendants and to the liability in case of accidents.



### III. Findings and Discussion

#### 1. *The Territory and the People*

Hawaii's population of nearly 500,000 (493,000 including 25,000 or more military personnel as of July 1, 1950), is distributed over an area of 6,407 square miles, as compared, for example, with over two million people who occupy 4,820 square miles in Connecticut. But the people of the Territory are living in five counties, with 69 per cent in Honolulu, 15 per cent in Hawaii, 10 per cent in Maui, 6 per cent in Kauai, and 0.1 per cent in Kalawao. The eight principal islands are separated by bodies of water of the Pacific, but six are quickly and easily reached by airplane services.

Nearly 40 per cent of the population are Japanese, while 19 per cent are Hawaiian or Part-Hawaiian, 18 per cent Caucasian, 13 per cent Filipino, and the remainder Chinese, Puerto Rican, Korean, and other. The decrease in mortality rates during the past twenty years has been striking; birth rates have been relatively high in comparison with the United States as a whole. Death rates from maternal and infant mortality are among the lowest in the United States. The last case of smallpox in the Territory was reported in 1913, thirty-seven years ago; there are no cases of rabies; last year there were 8 cases of diphtheria, but there have been no deaths for five years; there were 3 cases of typhoid fever, but no deaths since October, 1946; there were 18 cases of whooping cough with no deaths since March of 1948. In contrast, ten years ago, diphtheria, whooping cough and typhoid fever took 39 lives. In 1949, tuberculosis reached a new low of 107 deaths. Nearly 28 per cent of the deaths in 1949 were due to diseases of the heart, with 14 per cent to cancer and other malignant neoplasms, followed by 9 per cent from cerebral hemorrhage, and slightly less than 5 per cent each to premature birth and to pneumonia and influenza, as the six leading causes of death. The contrasts in death

rates per 100,000 population are shown in the attached table, for selected years, and presented for illustrative purposes.

The savings in lives and the reduction in incapacity, each year, are due in no small degree to constructive inexpensive programs carried on by loyal and industrious members of professional staffs, to doctors, dentists, nurses, hospital employees, and many others, besides thousands who support the services, and to many other factors, not mere accidents. These services and those of the plantations have paid large dividends. Larsen has described plantation medicine in an able manner and shown some of the results, including striking reductions among the 70,000 to 100,000 people in the last ten years in infant mortality, diarrhea and enteritis and other illnesses.<sup>6</sup>

Chronic disease deaths have increased sharply. The expectation of life at birth for Hawaii has risen in a manner to compare favorably with gains on the mainland.

#### 2. *Responsibility for Public Health*

As with a business organization, so also with public health, there must be a proper design for the division of work and a delegation of responsibility. This statement was made by a former President of the State and Territorial Health Authorities. The functions and responsibilities of the state and federal government have been increasing over the years. Furthermore, both the federal government and voluntary agencies have legitimate responsibilities in this field. The United States Public Health Service administers foreign and domestic quarantine and licenses biological products shipped in interstate commerce. It supplies medical care to certain persons designated by law, conducts research investigations in public health, and cooperates with state and local health officials and with universities. Essential health services in behalf of mothers and children, including crippled children, are furnished by the Children's Bureau. The Army, the Navy, the Veterans Administration and a variety of other federal agencies furnish additional health services. Voluntary or non-official agencies provide a significant portion (possibly a fifth) of the financial support of all public health work in the United States and are needed to supply important services which an official agency may not be equipped or ready to render.

In the long run, the maximum economy in state and territorial expenditures for the mental and physical well being of the citizens is conditioned upon the provision of an adequate prevention program. For example, prevention of occupational diseases, industrial and home accidents, and of

TABLE 1.—Deaths from Selected Causes per 100,000 Population, Territory of Hawaii—1920, 1929, and 1949

CAUSE OF DEATH	1920	1929	1949
Heart disease .....	77	121	171
Malignant neoplasm .....	58	66	86
Vascular lesions (CNS) .....	..*	54	55
Premature birth .....	..*	44	30
Accidents .....	..*	76	33
Motor vehicles .....	..	(20)	(12)
Other .....	..	(56)	21
Tuberculosis .....	205	111	23
Pneumonia and influenza .....	240	159	29
Diabetes mellitus .....	7	13	22
Nephritis and nephrosis .....	68	66	16
Congenital malformations .....	..*	14	14
Diphtheria .....	7	9	0
Typhoid fever .....	15	4	0
Diarrhea and enteritis .....	147	126	7
Whooping cough .....	2	28	0
Puerperal .....	..*	21	1
All other .....	949	313	129
Total .....	1775	1225	616

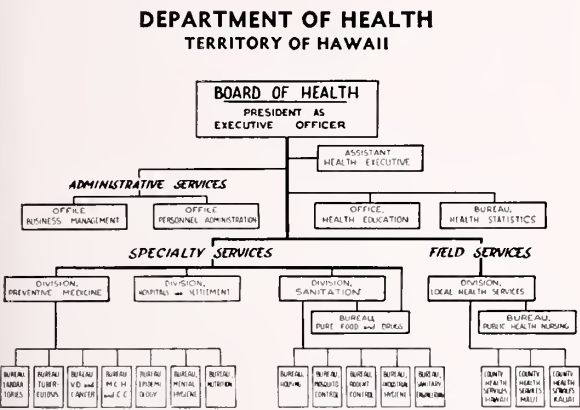
\* Given in "All other."

<sup>6</sup> Nils P. Larsen, M.D., *Industrial Medicine and Surgery*, Vol. 19, No. 8, August 1950.

tuberculosis and syphilis, is less expensive than treatment of physical conditions resulting from these causes.

3. *The Department of Health of Hawaii*

The Department of Health is the organization chiefly concerned with features of public health shown on the attached chart. The major activities of each section and the background of public health in Hawaii are described elsewhere in reports and in special bulletins of the Board of Health and of the Public Health Committee of the Chamber of Commerce.



*Personnel*

The total number of employees on the payroll for July, 1950, was 639, three more than in June; ninety-three were paid from federal funds. Fifty positions were vacant, including 8 in public health nursing, one in health education, 7 in preventive medicine exclusive of nursing, and a new position as medical health officer of Maui, besides the following key positions for which the Legislature failed to provide funds: Chiefs of Preventive Medicine, Hospital Study and Planning, Local Health Services and Dental Health—each requiring full-time professional leaders, and entailing heavy and complex duties which have to be assumed by an already overloaded executive and assistant executive. Hawaii and Kauai have full-time medical health officers; the assistant executive of the department carries the position in Honolulu.

*Finances*

The following summary table shows expenditures for the year ended June 30, 1949, exclusive of the expenditures by the section on Hospitals and Settlement, recently transferred to the Department of Health.

ACTIVITY BUREAU, DIVISION	TOTAL, FEDERAL AND TERRITORIAL	TERRITORY ONLY
Administration .....	\$ 160,116.85	\$ 98,700.25
Local Health Services.....	51,599.76	39,691.87
Preventive Medicine.....	320,645.10	182,665.48
Sanitation .....	85,445.50	78,362.05
Honolulu, C. & C.....	642,385.83	586,299.23
Hawaii .....	329,950.77	308,380.94
Maui .....	176,475.18	163,183.20
Kauai .....	96,510.81	90,016.73
Personnel Training.....	3,408.92	.00
Other Expenses.....	270,507.40	241,263.17
Special Projects.....	110,954.12	.00
TOTAL .....	\$2,248,000.24	\$1,788,562.92

The appropriation for the present biennium from the Territory amounted to \$3,538,690, in comparison with \$4,472,314 requested. Requests for 97 new positions, each necessary for successful work, and including 29 professional and clerical positions in nursing, were granted in only 8 positions. No provisions were allowed in Territorial funds for adequate consulting travel, inter-island, or for visits to the mainland—so essential for efficiency.

*Housing*

The housing of the Department of Health in Honolulu and on the other islands is a matter of considerable concern. The space at present amounts to 22,000 square feet in the central building constructed in 1884 and increased in size in the same style in 1930. Public Health Nursing, and Hospitals and Settlement, are housed in a nearby building; tuberculosis is nearly two miles away in buildings constructed for other purposes; cancer, heart and venereal disease sections are over 4 miles away in another direction; while mental hygiene is nearly 3 miles in a different direction, at the University of Hawaii by courtesy. It has been carefully estimated that a building of 67,000 square feet is needed now to house satisfactorily the Department and its bureaus. Services are reduced, the public and employees are inconvenienced, morale and teamwork are handicapped, laboratory activities are conducted under almost hazardous and very crowded conditions, to mention only some of the problems. Conditions on Hawaii, Kauai, and Maui, as well as Molokai, need attention also, for adequacy of space, healthy and properly lighted working conditions.

*Structure*

The Territorial Department of Health is well administered and is performing many essential services in an able manner. It needs reinforcement to provide for a more stable administrative staff structure, including the medical health officer of Maui, Chiefs for Preventive Medicine, Dental Health, Hospital and Medical Care, Local Health Services, School Health Services, and an Assistant Chief for Health Statistics, as well as assumption



by the Territory of the costs of essential key positions now carried on federal funds, including the Chief of Maternal and Child Health and valuable staff members in health education and in nursing.

The Department has the confidence of both professional and lay groups. The organization of the Department of Health, with a Board of Health—sometimes called a Public Health Council—is in general sound. It is essential that primary responsibility for health be vested, as it is now, in a separate body, non-partisan in character and composed of members professionally qualified to deal effectively with the problems of public health.

The statutes should place more specifically upon the Chief Executive of the Department the authority and responsibility for the appointment and direction of his subordinates and for the direction of all administrative activities of the department. Internal organization in the department should be left flexible in the hands of the Executive and heads of sections. Qualifications should be prescribed for the Executive (President of the Board of Health)<sup>7</sup> in the statutes, the salary scale should be increased to allow for \$15,000 now and rising to \$17,000 under present conditions. Other salary scales should be reviewed and revised in the light of responsibilities and of salaries paid for similar duties in other fields requiring advanced experience and training.

#### 4. *University of Hawaii*

The principal aim of the University of Hawaii, "to gear to the needs of the Territory the services and educational opportunities which we offer," is constructive in relation to opportunities in public health. A beginning has been made to provide instruction in nursing, in health education, and in undergraduate courses which help to provide an educational and scientific background for students who may enter the field of public health. Under the auspices of the University, the Psychological Clinic has rendered extensive services to a variety of agencies for many years. Opportunities for conferences, special studies and workshops on various subjects have been provided and used advantageously. Up to the present time, funds have been lacking for a comprehensive university health service of the purpose and scope provided especially for students in state universities such as California, Kansas, Michigan, Minnesota, and Ohio, for example.

Fortunately, steps are in progress to develop a program of nursing education through cooperation of the University with the hospitals in a

practical manner in keeping with experience in leading centers on the mainland. An urgent need exists for more emphasis on health in teacher training. A great contribution can likewise be made on this campus through expansion, as the need is indicated, of the summer and special conference and study programs with particular reference to mutual interests of men and women of the Pacific area in affairs of health and of education. The need for a full-time experienced medical director of the University health service, with an adequate staff, including more provision for student psychiatric counselling, also deserves exploration. Meanwhile, consideration might also be given to the rearrangement of the section and the work of the Psychological Clinic in a manner more closely identified with the program of the Territory in mental health, bearing in mind the need to preserve the many valuable features of the work of members of this specialized staff.

#### 5. *Department of Public Instruction*

Several activities in the Department of Public Instruction serve as a part of the public health program, while others are related. It is important that teachers are provided in institutions for pupils who are afflicted, in most instances temporarily, with Hansen's disease (Hale Mohalu), tuberculosis (Kula, Leahi, Mahelona), and for handicapped children in schools for the deaf and blind, in the Shriners' Hospital, and in the Maluhia Home, besides teachers especially trained to assist pupils with cardiac, hearing, speech, and vision problems.

Some attention has been given to nutrition, and a staff of 153 were employed last year in the school lunch program of Home Economics Education, with expenditures of \$431,215 (\$72,746 Federal). Some features of the Vocational Rehabilitation Service, especially educational, relate to the community health program also, and there a staff of 11 carried on activities with expenditures of \$99,716 (\$70,191 Federal). Of more direct connection in relation to a strictly health program were the provisions for Dental Health Education carried on by 35 dental hygienists, with expenditures of \$132,530 (besides separate dental clinics operated on a maintenance basis in some high schools). While classed as health education, the dental hygiene program is usually considered as a part of a school health program operating under the guidance for content of a physician or dentist trained in public health. Such assistance could be obtained by coordination with the Department of Health when a Chief of Dental Health is appointed. Coordination of this nature is essential,

<sup>7</sup> As long as the legislation provides for the Chief Executive to be the President of the Board of Health, provision should be made that in the absence of the Executive, the Assistant Health Executive serve as Acting President.



especially in view of the unusually high incidence of dental problems in the Territory and in view of the nature and scope of modern measures to prevent these conditions. This statement is made keeping in mind, however, the outstanding contribution to dental hygiene and dental health education made for many years in Hawaii, including the significant contribution by the Strong-Carter Dental Clinic especially for young children.

The other main section in the health program is the Division of Health Education with a staff of 68 (40 home instruction teachers, 3 speech therapists, 18 health coordinators, 2 audiometrists, 3 clerks and only 2 classed as health educators) and with expenditures of \$102,772. Two strong factors in the program for school health deserve emphasis for long-term planning. Increased help can come from the Joint School Health Committee of the Departments of Health and of Public Instruction. Perhaps one of the most important tasks is to give implementation to the plans described in School Health Policy, prepared by a committee under the auspices of the Department of Public Instruction and the Board of Health and printed in October, 1941. These plans and policies are still sound, and will be useful also for the Catholic School Department and the Advisory Committee which is about to be formed, for the school health program in the Catholic Schools.

#### 6. *Other Official Agencies*

Hawaii is the first Pacific outpost of America's health defense, as stated in the survey report of 1935. The health of Hawaii is of extreme importance to the rest of the United States and to the Army, the Air, and the Navy forces, and the contribution of these military service groups through cooperation in the operation of hospital and consultative services, and to voluntary support of health services is considerable. The offices with active staffs of the U. S. Public Health Service and the U. S. Veterans Administration carry on extensive programs in the Territory. Health is also a significant factor to the Territory in relation to industry, tourist travel and commerce.

The Department of Institutions operates several units, which have an important relation to public health. Especially is this true of the Territorial Hospital, under able direction and with a modern program and the new treatment center, the Oscar F. Goddard Hospital, dedicated to an intensive treatment program of new admissions. During the fiscal year ending June 30, 1950, an expenditure of \$1,522,413 was recorded for an average daily patient population of 1,087. The staff of 249 is recognized as too small professionally and otherwise for the heavy task; but the progress in treat-

ment is outstanding, and constructive plans are under way for more outpatient and field services.

Leahi Hospital is well known as an institution for the care and treatment of tuberculosis patients. It is well organized and ably administered and utilizes the best of modern methods of surgery and other forms of treatment while cooperating also with other institutions and agencies on Oahu and other islands. Expenses for the fiscal year ending June, 1949, amounted to \$1,575,818, exclusive of the important building program under way. New buildings for the care of tuberculous patients are also under construction on Kauai and Hawaii, while the building on Maui has a capacity sufficient to accommodate cases of other diseases, such as cancer. A policy to serve other cases is sound in view of conditions; furthermore, at Hilo, it is to be hoped that cooperation and coordination may be accomplished by the new tuberculosis hospital and the neighboring Hilo Memorial Hospital in view of community needs.

County general hospitals in Honolulu and in the Territory of Hawaii vary in the adequacy of resources, in methods of accounting and in status of building. These and other factors emphasize the need of continuing assistance in program guidance and planning for the benefit of the patient and the taxpayer. The new building to be erected on Maui is on grounds suitable also for a community health center, and needs an able administrator experienced in the operation of a modern hospital for successful attainment of the goals of local authorities.

The official agency primarily responsible for work in conservation of vision and prevention of blindness is the Bureau of Sight Conservation and Work with the Blind. For the fiscal year ending June 30, 1950, expenditures for personal services amounted to \$107,465; the 1951 fiscal year appropriation amounted to \$129,972, including \$12,435 for maintenance. Twenty-five Lions Clubs are reported to have expended \$8,006 last year for Sight Conservation and Blind work and these clubs are recognized as the chief voluntary agency in this field. This important work has a direct relation on the medical side to that of the Bureau of Maternal and Child Health of the Department of Health, while it is also related actively from the educational standpoint to many activities of the Department of Public Instruction. Certain educational features relate to the services of both departments. While there were apparently good reasons in the earlier days for having a separate department to feature this important work, with offices on all islands, it would appear wise now to consider the reorganization possibilities to com-

bine those features which are essentially in the health field with others in progress in the Maternal and Child Health Bureau, while the essential educational phases and the appropriate amount of the present budget and personnel would be allocated to the Department of Public Instruction. Such a step seems to be in line also with featuring the child and the family needs more nearly as a whole.

The Department of Public Welfare has direct relation with health, dental and medical affairs at several points. The operation in relation to costs of medical care for indigents is recognized as unusually complex, with payments to general hospitals on a cost basis, but without power to pay certain county hospitals on a similar basis, and without a systematic plan for remuneration of physicians rendering care. At present, the Department lacks a medical director or chief of the medical services, and the salary allowed for the position is much too low to attract a qualified doctor. Three physicians are employed part-time as ophthalmologists on the neighboring islands, besides a medical consultant in Honolulu and the purchase of medical services from The Medical Group as earlier approved by a medical advisory committee. Expenditures in 1949 for medical services alone, as distinguished from staff administration and relief, amounted to \$553,457. The need is apparent for clarification and systematization of the medical care plan for indigents. Studies of the Advisory Group to the Holdover Committee should be helpful in this regard. The Maryland Plan, with administration by the Board of Health of this technical medical service, is worthy of study for possible adaptation to conditions in Hawaii.

Hansen's disease presents a problem of medical significance which is of primary concern to the Board of Health. The magnitude of economic and social problems and associated administrative responsibilities sometimes almost overshadows the medical problems, and always requires an enormous amount of energy, skill and time of the authorities immediately concerned. Commendable progress has been made in the operation of the settlement on Molokai and of the program in Honolulu. The services are naturally expensive for the number of cases involved; but much of the budget is for non-medical items. The problem is unique in Hawaii and will require continuing study, well considered steps in a transition period, and use of the technical information for guidance from many sources including those resulting from studies by the U. S. Public Health Service, the Territorial Department of Health and other au-

thorities contributing to modern knowledge of this disease.

Another difficult problem, with varied opinions regarding its solution, is the method of providing emergency medical and surgical care by the counties or by other official groups, especially in Honolulu. Methods on the mainland differ. A plan in Detroit is of interest, and the 1949 memorandum of agreement deserves study as made between the Department of Public Welfare of the City and the Greater Detroit Hospital Council, representing member hospitals of the City of Detroit. Opinion, based on experience, favors generally having the general hospitals operate emergency rooms and emergency units, for many of the accident victims, for example, require the most elaborate hospital facilities without delay. In Cleveland, the City Hospital has the emergency rooms needed to take care of patients, but the Police Department operates the ambulances. In some cities, the fire department operates the emergency ambulances. There is much in favor of having qualified general hospitals operate emergency room and surgical service on a reasonable pay basis. There is little to recommend for an independent emergency unit. There is a question if such hospitals should operate emergency ambulance services, especially if appropriate arrangements can be made with either police or fire departments.

Two other problems may assume increasing importance for both official and voluntary agencies in Hawaii—namely, gaps in provisions for adult mental hygiene, with adequate outpatient services needed throughout the Territory and particularly in Honolulu, and with resources for persons of moderate incomes now lacking; and the need for more effective care of chronic illness and for a more constructive, systematic and positive program of geriatrics. As time goes on, there may be a more striking need for community bedside nursing services, perhaps on an hourly basis, and involving a wider use of trained practical nurses under the supervision of experienced graduate nurses, and of visiting housekeepers. Some physicians and numerous potential consumers and taxpayers reported existing opportunities for such services. Associated with these programs, well qualified social workers will also be required (besides meeting the existing shortage in some institutions), as well as other professional workers and measures to promote the related facilities for dental health. Such developments as those embraced in the above outlined opportunities need to be planned, however, as parts of a properly conceived, technically guided, and wisely executed community health program.



### 7. *The Voluntary Agencies*

The voluntary health movement is greater in extent and wider in variety in the United States than elsewhere in the world. Voluntary agencies in Hawaii form a permanent and important part of the health machinery and reflect the generosity, genius, and good will of thousands of men and women who give time and money. Hundreds of volunteers render important service on boards and committees and give assistance in many capacities, working with loyal professional staffs in carrying forward the programs of these agencies for the prevention of illness and the promotion of health. Furthermore, many of the activities initiated by voluntary agencies are—and should be—ultimately turned over to official governmental departments. When this happens, however, as when speech teachers and nutritionists, laboratory workers, physical therapists, and radiologists, for example, are paid from official funds, the voluntary agency should not go out of business but transfer its pioneering activities to new fields. One of the more fruitful fields for cooperative endeavor is in the provision of liberal scholarship assistance for residents of Hawaii who wish to study in graduate schools in Hawaii and on the mainland.

In Hawaii, Palama Settlement was one of the earliest of the voluntary agencies in the fields of health, recreation, and welfare. Essential nursing services became a part of official nursing; the dental services have now been established on a separate basis under the well equipped Strong-Carter Dental Clinic; and since the outpatient department of Palama was transferred to Queen's and St. Francis Hospitals, the health program there has been reduced to physical examinations for members and to members renewing cards. Moving pictures from the Board of Health are used regularly at Palama to acquaint parents with matters of health. An expansion of these services is being considered to provide more careful follow-up of health examinations and of individual emotional and health problems of children.

The primary purpose of the Strong-Carter Dental Clinic (formerly the Honolulu Dental Infirmary) in 1920 was to provide dental care for the children of Honolulu whose parents were not financially able to have them treated by a private dentist. A training school for dental hygienists was also sponsored and financed by Mrs. George R. Carter in 1921. Since 1920, over 47,000 children have received dental care in the clinic at a cost of nearly \$900,000, a project which represents an investment of about \$35,000. Except for orthodontics, the Clinic provides routine services of a children's dental clinic, including sodium fluoride

treatments. In a year, a staff of five dentists and five assistants, now being enlarged, cares for nearly 2,700 children of Honolulu at a cost of about \$50,000.

A new voluntary agency for educational, library, meeting and office purposes, is the Mabel Smyth Memorial Building, a center of great activity, housing the medical and nursing societies and providing excellent library resources and comfortable meeting rooms, especially an unusually comfortable and well-equipped auditorium. This center is operated by a manager under a Board of Management of five members.

In Hawaii there are over 30 voluntary health agencies exclusive of many organizations which participate in community health activities, such as the Public Health Committee of the Chamber of Commerce, Medical and Dental Societies, the American Red Cross, group work agencies, 4-H Clubs, service clubs, Congress of Parents and Teachers, Junior League, and Federation of Women's Clubs. The expenditure of 20 of these agencies last year, for example, amounted to \$2,928,500.

A partial list of voluntary health agencies, exclusive of hospitals, clinics, medical, dental, and nursing societies, includes the following:

- Blood Bank of Hawaii,
- County Chapters of the National Foundation for Infantile Paralysis,
- Hawaii Cancer Society,
- Hawaii Heart Association,
- Hawaii Public Health Association,
- Mental Hygiene Society of Hawaii,
- National Society for Crippled Children and Adults, Hawaii Chapter,
- Tuberculosis and Health Association of Hawaii,

with branches or similar associations on each of the larger islands, and the Oahu Health Council. The Honolulu Council of Social Agencies attempts to promote social welfare by coordinating the work of all public and private welfare organizations and promoting cooperation in their operation. It operates the Confidential Exchange, which, through registering cases from all casework agencies on a territory-wide basis, eliminates duplication, so far as individual help is concerned. The only major health agency in the Community Chest is the Mental Hygiene Society with an enlarged allotment for 1951 amounting to \$9,950.

During the course of this study, joint discussions have been held with Board members and executives of each of the major voluntary agencies in Honolulu, Hawaii, Kauai, Maui, and Molokai, and the proposals made above summarize the major items to be considered in the near future, except for the joint enterprises which may be developed with the Health Council.



There are ultimate needs to be met, as follows:

1. Increased and continuous coordination between public and private health agencies and their activities.
2. Increased and continuous cooperation and coordination of the health agencies and activities of the four counties in Hawaii.
3. Continuous planning to meet all health needs of the metropolitan community through prevention of overlapping and duplication and expansion where necessary, with due consideration of proper relationships with social agencies and medical care institutions.
4. Helping with the development by official and voluntary agencies of a continuous health education program.
5. Special research and reports on specific health problems as needed with action to put recommendations into effect.
6. Central source of health information.
7. Furtherance of needed legislation.
8. Publication of bulletin of value to all agencies.

### 8. *Health Councils*

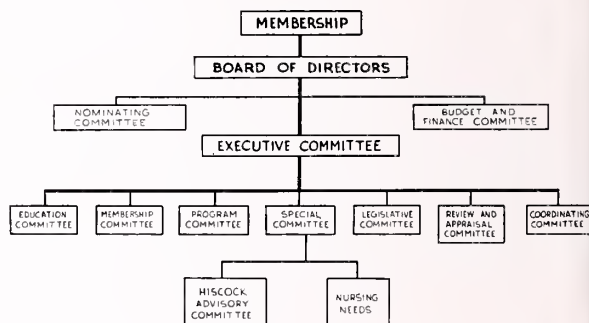
The numerous voluntary and official agencies serving the people of Hawaii are in general well organized and have sound objectives. Many have developed good structures and on-going programs. From the standpoint of the community as a whole, however, some of the programs are not related to other agency activities in the same or related field, and there is often a chance to use resources to better advantage. Conditions are improving and the basic work has been done, and the mechanism is established in the Oahu Health Council. This Council evolved from the program and activities of the Public Health Committee of the Chamber of Commerce.

It is noteworthy that this committee, successor to the "Shippers' Wharf Committee," had the benefit of some of the funds from the public health tonnage charge, and that in 1941, the late Judge A. G. M. Robertson ruled that while no epidemic or other emergency existed, the money could be applied to other subjects of public health. Throughout the years, the money was used for studies in public health, for the essential projects in support of the work to meet needs of both government and voluntary agencies. Similar funds have been used on Hawaii and other islands by local committees. The accomplishments have contributed to the favorable health picture enjoyed today.

The Health Council is serving an important place in the community as a democratic organization, and each member is gaining a feeling of belonging, of working-togetherness, of interest, and responsibility so essential for continuing success. This is not just another organization to replace existing health agencies. Its objectives and

constitution are carefully conceived and allow for essential flexibility in the development and carrying out of tasks based on group judgment. It is properly recognized as primarily an organization for help in program planning, coordination, study—joint study and cooperative action—with aims also to help in interpretation of agencies and activities to the public and to each other, while avoiding specific activity projects of competition with other organizations and agency members. It should be intimately related to and assist in the work relating to health of member agencies of the Council of Social Agencies. The latter organization should not need a separate committee or division. Pending the time when details may be perfected to have the Oahu Health Council serve also as the Division for Health of the Council of Social Agencies, as is the case in Columbus and Cleveland, Ohio, in Milwaukee, and in Boston, for example, it is hoped that practical methods can come from special committee action and careful liaison provisions between the two Councils, through board members as well as executives.

### OAHU HEALTH COUNCIL HONOLULU, OAHU



As indicated in the proposals, a budget of around \$20,000 a year should be regarded as minimum. The executive needs to spend much time among the agencies and out of the office and requires a good clerk-stenographer or secretary. The agency bulletin serving the member agencies should be re-established as one of the useful instruments in accomplishing the objectives, bearing in mind the audience and the purposes as both different from those receiving the valuable and essential *Health Messenger* of the Department of Health.

Among the immediate needs of activity for the Council are exploration and working committee recommendations on future plans to meet needs (if found to exist) in alcoholism and mental health; personnel recruitment, and training including scholarships; helping with health education workshop in materials spearheaded by the

health education group; nursing (many topics for an effective nursing council or committee); hospital and community affairs (jointly perhaps with Public Health Committee of the Chamber of Commerce); dental health; rehabilitation center; and follow-up on this survey; besides giving preliminary advice if needed to leaders on other islands toward the formation of local Councils, and joining in the establishment of a Territorial Health Council in line with suggestions of the National

Health Council, the State Health Council of Massachusetts, and in line with proposals of the American Medical Association and many other professional and lay organizations.

The objectives are worth the effort. The canoe is not likely to be swamped by the outside wave but by the inside wave. Courage, faith and patience will be needed; but they are in abundance with the additional strength of wise leadership and skill in Hawaii.

## PRIMARY ANORECTAL ABSCESS

### A Modern Concept of Pathogenesis and Treatment

V. C. WAITE, M.D.

HONOLULU

ANY improvement in the management of acute primary anorectal abscess which would significantly reduce the subsequent occurrence of anal fistula, should be enthusiastically received by everyone.

In recent years, many surgeons have resorted to a more extensive surgical procedure as first treatment in the abscess stage, which has yielded more encouraging results. This consists simply of considering the primary abscess as the first sign of an already present fistula, and treating it as such from the beginning. This approach is in marked contrast to the still widely used technique of merely draining the abscess and then waiting for the fistula to form, which it does in about 75 per cent of cases.

#### Material and Methods

This study consists of 21 consecutive cases of acute primary anorectal abscess which were treated



DR. WAITE

largely during 1947 and 1948. Patients who developed an abscess incident to an already existent fistula, or who had had a previous anorectal abscess, were excluded.

These cases were divided into two groups for purposes of study. Group I consisted of 10 patients seen during 1946 and 1947, and treated by simple wide incision and drainage. The next 11 cases, Group II, were seen in 1948 and 1949, and were treated by fistulotomy in addition to incision and drainage. These two groups of cases, though small in number, are comparable (Table I and Table II). Group I cases were not all hospitalized, some having been incised and treated as out-patients. Either sodium pentothal or nitrous oxide was the anesthetic in 9 cases; local procaine sufficed in one. Incision and drainage consisted of the removal of a segment of skin to completely unroof the abscess in all cases. Several penrose drains were inserted and removed at intervals over a period of about four days and hot saline compresses and Sitz baths were used liberally. The average length of follow-up on this group was twenty-five months, and results are summarized in Table I. It will be noted that 7 patients in this group subsequently developed fistulas with recurrent abscesses, and 3 healed without complication.

Group II patients were all hospitalized and operated upon as emergencies. Low spinal anes-

From the Department of Surgery, The Clinic, Honolulu, T. H. Read before the Honolulu County Medical Society, February 3, 1950.



thesia, with 50 mg. of procaine and 0.5 mgm. of epinephrine, was used in each case to provide adequate relaxation. The anal canal was first thoroughly explored in an effort to discover an internal opening. In several cases this was successful, frank pus being identified, usually flowing from an inflamed crypt. If the internal opening could not be discovered, the abscess was unroofed, evacuated, and its communication with the anal canal explored from within. In 4 cases of this group, an internal opening could not be accurately identified. However, it was noted that the wall of the abscess was invariably thinnest in the vicinity of the dentate line. In these instances, one or two crypts closest to the abscess cavity were excised.

TABLE 1. (Group I)—10 Consecutive Cases of Primary Anorectal Abscess Treated by Incision and Drainage Only.

CASE	SEX	AGE	LOCATION OF ABSCESS	RESULT	PERIOD OF FOLLOW-UP
R.W.	F	34	Ischioanal	Recurrent Abscesses & Fistula	12 Months
H.T.	M	23	Ischioanal	Abscesses & Fistula	7 Months
O.G.	M	41	Ischioanal	Healed	24 Months
A.L.	M	49	Retorectal	Fistula	24 Months
J.N.	M	16	Ischioanal	Healed	5 Months
D.R.	M	12	Ischioanal	Fistula	12 Months
A.C.	M	35	Ischioanal	Fistula	36 Months
C.H.	M	41	Ischioanal	Recurrent Abscesses & Fistula	40 Months
R. I.	M	28	Ischioanal	Abscesses & Fistula	48 Months
C.N.	F	34	Ischioanal	Healed	42 Months

TABLE 2. (Group II)—11 Consecutive Cases of Primary Anorectal Abscess Treated by Incision and Drainage Plus Fistulotomy.

CASE	SEX	AGE	LOCATION OF ABSCESS	LOCATION OF ANAL CANAL OPENING OR CRYPT	RESULT	LENGTH OF FOLLOW-UP
K.T.	M	29	Ischioanal	Rt. Lat. Int. Op.	Healed	11 Mos.
S.A.	M	11	Ischioanal	Post. Comm. Int. Op.	Healed	17 Mos.
R.B.	M	59	Subcu	Post. Comm. Int. Op.	Healed	6 Mos.
M.H.	F	36	Ischioanal	Post. Comm. Int. Op.	Healed	9 Mos.
T.N.	M	21	Ischioanal	Rt. Lat. Crypt	Healed	8 Mos.
W.P.	M	36	Ischioanal	Post. Comm. Int. Op.	Healed	6 Mos.
J.H.	M	31	Ischioanal	Post. Comm. Int. Op.	Healed	8 Mos.
T.N.	M	47	Pelviorectal	Post. Comm. Crypt	Healed	7 Mos.
A.M.	M	33	Ischioanal	Post. Comm. Crypt	Healed	19 Mos.
M.D.	F	48	Ischioanal	Post. Comm. Crypt	Healed	7 Mos.
H.D.	F	36	Ischioanal	Post. Comm. Int. Op.	Healed	5 Mos.

After identification of an internal opening, or a probable involved crypt, the tract communicating with the abscess was exteriorized by fistulotomy and curetted. If the sphincter muscle was involved, it was transected at a right angle to its fibers.

During the postoperative period, each of these cases was examined daily, or at least every other day, in order to insure progressive healing from the depths of the wound outward. The average period of follow-up in this group was ten months, and at the end of the follow-up period, it was gratifying to note that all of these lesions had healed without evidence of residual inflammatory activity. These results are indicated in Table II.

## Discussion

For some time, surgeons have been aware that para-anorectal infections originate from one of four structures: (1) the anal canal, (2) perianal skin, (3) posterior urethra and associated glands, and (4) sacrococcygeal cysts. It is also commonly known that the vast majority begin in the anal canal within one of the anal crypts of Morgagni, usually at the posterior commissure, and it has been demonstrated repeatedly that abscesses and fistulas are found to communicate with this portal in approximately 90 per cent of the cases. Although the anal crypts have been thus indicted for some time, the mechanism of transference of infection to the perianal and perirectal spaces, and the pathogenesis of anorectal abscess and fistula in general have been somewhat obscure.

It has been generally assumed that pathogenic bacteria from the anal crypts reach the para-anorectal spaces by way of the lymphatics or by direct extension from an injury to the anal wall. Certainly this must be the explanation in some instances. However, more recently, the proctologist has been inclined to point the accusing finger at small vestigial epithelial lined tubes which open into the crypts, usually in the posterior segment of the anal canal. These structures are referred to as the anal ducts.

It has been stated that Herrmann and De Fosses,<sup>1</sup> in 1880, while studying the anorectal region of the human embryo, very adequately described epithelial lined, sinus-like, often branched channels which emptied into the anal crypts of Morgagni. They noted these structures to be lined with a transitional type of epithelium, which was different from the mucosa of either the rectum or the anal canal, and suggested even at this early date that they might represent a point of entrance for perianal infection. These anatomic observations have been repeatedly confirmed, and more recently extended, by Lockhart-Mummery,<sup>2</sup> Gordon-Watson,<sup>3</sup> Tucker and Hellwig,<sup>4</sup> Morgan,<sup>5</sup> and Kratzer and Dockerty.<sup>6</sup> These and other authors have demonstrated the existence of these structures in humans, more commonly in the embryo and infants, but often in the adult. Kratzer and Dockerty showed that the majority of these

<sup>1</sup> Herrmann, G. and DeFosses, L. C.: *Compt. Rend. Acad. Sci.* 90: 1301, 1880. Cited by Kratzer.<sup>6</sup>

<sup>2</sup> Lockhart-Mummery, J. P.: *Proc. Royal Soc. Med.* 1331, 1929. Cited by Tucker.<sup>4</sup>

<sup>3</sup> Gordon-Watson, C. and Dodds, H.: *Observations on Fistula in Ano with Relation to Perianal Intramuscular Glands*, *Brit. J. Surg.* 22:703 (Apr.) 1935.

<sup>4</sup> Tucker, C. C. and Hellwig, C.A.: *Histopathology of the Anal Crypts*, *Surg., Gynec. and Obst.* 58:145 (Feb.) 1934.

<sup>5</sup> Morgan, C. N.: *Postgrad. M. J.* 12:287, 1936. Cited by Kratzer<sup>10</sup> (also by personal communication).

<sup>6</sup> Kratzer, G. L., and Dockerty, M. B.: *Histopathology of the Anal Ducts*, *Surg., Gynec. and Obst.* 84:333 (Mar.) 1947.



ducts open into the crypts at the posterior segment of the anal canal, and that where evidence of cryptitis existed in their specimens, the anal ducts were likewise involved in 90 per cent of the cases. These two observations added further pointed evidence that an inflammatory process, in the crypt and anal duct, might well be the portal of entry to the para-anorectal compartments from which an abscess and subsequent anal fistula could develop.



FIG. 1. Type of incision used for drainage in Group I cases.

At this point, common sense immediately suggests that the treatment of anorectal abscess, in the majority of instances at least, should be based on the assumption that the cavity communicates with the anal canal and that actually a fistula already exists. Such a concept would seem unavoidable if one could be sure that the abscess in question did not originate from the posterior urethra, prostate, Cowper's glands, sacrococcygeal cysts, or other less frequent sites.

Simple incision and drainage of these abscesses through the skin is neither adequate nor definitive; the internal opening, or the correspondingly involved crypt, must also be excised or opened at the same time. In other words, fistulotomy, or fistulectomy, should usually be added to simple incision and drainage. Since an operative attack is made within the anal canal, anesthesia which offers good relaxation of the perineal muscles is

essential, and special instruments are required. Accordingly, such treatment should usually be done in the hospital.

This principle in anorectal surgery has not been widely appreciated by general surgeons and general practitioners, although many proctologists<sup>7</sup> have utilized the method for approximately the past ten years. I have used it in the management of my own cases since early in 1948, and, as the above results have indicated, experience thus far with this technique has been most gratifying.

### Summary

From the investigations of several workers it seems evident that infection from the anal canal may reach the para-anal spaces by way of the anal ducts in the majority of instances.



FIG. 2. Incision and drainage of abscess with fistulotomy as used in Group II cases.

Fistulotomy done at the time of incision and drainage of a primary anorectal abscess constitutes a significant advance in the management of this disease.

Case studies are presented which tend to confirm these principles.

<sup>7</sup> Herrmann,<sup>1</sup> Fansler,<sup>8</sup> Wenzel,<sup>9</sup> Kratzer.<sup>10</sup>

<sup>8</sup> Fansler, W. A.: Anal Fistula and Abscess, *Am. J. Surg.* 56:144 (Apr.) 1942.

<sup>9</sup> Wenzel, J. F.: Anorectal Abscess, *Am. J. Surg.* 72:517 (Oct.) 1946.

<sup>10</sup> Kratzer, G. L.: 1949 Transactions of American Proctologic Society.



## *The President's Page*

THE most important thing for doctors to do in preparation for an atom bomb attack is to learn how to take care of burns.

Experience has shown us that 85 per cent of the casualties we will be called upon to treat will be burn casualties. This will be the primary problem, and the urgent problem. Radiation effects can be dealt with later, and even the victims of these are likely to present thermal burns which must be treated first.

Modern methods of treatment of burns have been reviewed and catalogued, and a printed copy of this manual is being sent to every physician in Hawaii. A concise summary of this will be published in the next issue of the HAWAII MEDICAL JOURNAL. Every physician is urged to familiarize himself with this outline of procedure. If it should "happen here" again as it did once before, let us be as ready for it next time as we were the last time!

*Rogers Lee Hill*

# Hawaii

## MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D. Editor  
LYLE G. PHILLIPS, M.D. Editorial Director  
MRS. EDITH C. BENNETT Managing Editor  
LAURENCE M. WIIG, M.D. Assistant Editor  
ROGERS LEE HILL, M.D. Advisory Board  
JAMES R. ENRIGHT, M.D. Advisory Board  
HASTINGS H. WALKER, M.D. Advisory Board  
PETE OKUMOTO, M.D. Associate Editor, Hawaii  
KEITH KUHLMAN, M.D. Associate Editor, Kauai  
E. T. SHIMOKAWA, M.D. Associate Editor, Maui

### [ EDITORIALS ]

#### THE HISCOCK REPORT, 1950

"The Hiscock Report" has become something of an institution in medical affairs in Hawaii. Three times now, in 1929, 1935, and 1950, Dr. Ira Hiscock has come from New Haven to Hawaii, reviewed our public health agencies, and left us with a constructive critique of their functions and relationships and useful, practical advice for our guidance in planning for the future. The first survey was made under the auspices of the United Welfare Fund (later the Community Chest); the second, at the request of the Chamber of Commerce; and the current one, under the auspices of the Oahu Health Council, though with the financial support of a number of health agencies.

The complete text of the 1950 report is published in this issue of the JOURNAL. Doctor, do yourself and the community a favor by reading it! If you take time for nothing more, read at least, on pages 100 and 101, the summary of the strong and weak features of public health agencies in Hawaii—the compliments, and the brickbats.

We do not propose to attempt anything so elaborate or so arrogant as a critique of Dr. Hiscock's recommendations. We do not hesitate to point out, however, that they are entitled, on the basis of his past performances in our behalf, to the most serious consideration. This consideration is already being accorded them, by the legislative committees of the Oahu Health Council, the Honolulu County Medical Society and the Hawaii Territorial Medical Association, and by the Public Health Committee of the Chamber of Commerce, as well as by other interested organizations. It is important that physicians of Honolulu, with their special knowledge of the problems encompassed

by these recommendations, take an active and constructive part in the deliberations whereby these recommendations will be translated into remedial legislation.

So, Doctor—please, take just twenty minutes off and read the report. Dr. Hiscock went to a lot of trouble to make it available for you—let's at least make his time well-spent.

#### PARATHION POISONING

Parathion, a deadly new insecticide, is being used by more and more people. Physicians have the responsibility of knowing the symptoms of parathion poisoning and its specific treatment. This is particularly true of physicians treating Hawaii's rural population, but since many "city slickers" are amateur farmers and gardeners, Honolulu physicians also may encounter parathion poisoning.

Parathion, an "organic phosphate," is related to tetraethyl pyrophosphate, TEPP, which has been used with some success in the treatment of myasthenia gravis. Both compounds may cause death, in both insects and man, by their anticholinesterase activity. They neutralize cholinesterase, permitting acetylcholine to accumulate in the body, producing massive parasympathetic stimulation.

Symptoms consist chiefly of profuse sweating, blurring of vision (due to constriction of the pupils), vomiting, diarrhea and abdominal cramps. Convulsions and death may follow within only a few hours.

The specific antidote is atropine in large doses: 1/60 to 1/30 grain intravenously every hour until the patient is out of danger. This blocks the action of the accumulated acetylcholine. Accumulation of



bronchial secretions and pulmonary edema may require suction and positive pressure oxygen.

Parathion insecticides are usually supplied as wettable powders containing 15 to 25 per cent parathion. Since this chemical is readily absorbed through the skin, lungs and gastrointestinal tract, users should wear respirator masks, rubberized gloves and apron. Goggles are desirable.

Parathion is being used extensively on pineapple plantations here (Special Report, PRI No. 18, Jan., 1950) and is sold in Honolulu as "Genethion" and "Penphos."

Other brands of parathion which may appear here with the passage of time are: Phos Kil, Vapophos, Thiophos, Paradust and Niran.

C. A. DOMZALSKI, JR., M.D.

### **SAMUEL SORBIERE AND THE "ALARM REACTION"**

"I have no doubt at all that with fear and with sadness, and in the more material illnesses, there is some failure in the irradiation of the vital forces, which forces do not flow in an even manner; or they encounter obstacles in their movement. Joy seems to exert such an effect on them that it opens the pores and enables the vital forces to pass to parts where they had not previously penetrated. . . . One sees the vital spirits disappear when sadness and fear are present. . . ." So, in 1672, wrote Dr. Samuel Sorbière, in his *Advice to a Young Physician*, recently translated by Dr. Frank L. Pleadwell.<sup>1</sup>

For the somewhat inexact expression "irradiation of the vital forces," read "secretion of the pituitary and adrenal hormones," and then note how precisely this 17th century physician anticipated the general theory of Selye's alarm reaction, with its seemingly widely differing causes of "fear

. . . sadness, and . . . the more material illnesses." Sorbière also recognized, and is at pains to describe here, examples of the actual therapeutic effect of heightened emotional reactions. "Gouty patients," he says, "have been given wings to flee their chambers upon a fire breaking out." And he describes an instance of the cure of a sciatica by an access of anger.

Sorbière will recommend himself to the modern physician in many other ways besides; his list of desirable accomplishments in a physician makes useful reading for a young man even today, and his account of consultations and their pitfalls might have been written in 1950.

### **OREGONIZED MEDICINE GETS GREEN LIGHT**

Government charges that Oregon's organized medicine had violated the Sherman anti-trust act were ruled not valid in Federal court on September 28, by Federal Judge Claude McColloch.

"I hold," wrote Judge McColloch, "that Oregon Physicians' Service is not a conspiracy but rather an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service, eliminating the evils of privately owned concerns as well as the element of private profit."

However one may regard Judge McColloch's feelings about the "evils of privately owned concerns . . . and . . . the element of private profit"—and we are still inclined to regard both private ownership and private profit as immeasurably superior, for most purposes, to public ownership and bureaucratic expenses—still, this is a victory for organized medicine and a pratfall for the Federal Security Administration and that portion of the Department of Justice which is concerned with meddling in medicine. Mr. Ewing, Mr. Alt-meyer and Mr. Falk must be pretty unhappy about the whole thing.

<sup>1</sup> Pleadwell, F. L.: Samuel Sorbière and his *Advice to a Young Physician*, Bull. History of Med. 24:255 (May-June) 1950.

**Anatomy Prof.: Name the bones in your hand.**

**Med. Student: Dice.**

1 1 1

**Doc.: You have heart trouble. Angina.**

**Med. Student: Pretty good guess, Doc, only her name is Angelica.**



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6844  
6-8865

THIRD FLOOR • YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 • 7-8411

# MEDICAL NEWS

Several British reports discuss "medical sympathectomy" produced by **methonium compounds**. These substances, like tetraethylammonium chloride ("Etamon") block the synapses in autonomic ganglia, but have the advantage of being effective orally. **Hypertensive patients** can be maintained with about 1 gram t.i.d. Postural hypotension is the only drawback. (Turner, R., p. 353, and Saville, S., p. 358, *Lancet* [Sept. 2] 1950.)

**Khellin**, crystalline derivative of Ammi visnaga, a plant which grows abundantly in the Eastern Mediterranean region, has been shown to dilate coronary arteries in animals. Best and Coe now report reversion to normal of electrocardiograms in 71 per cent of patients with **angina pectoris** who were given Khellin. The majority of patients were relieved of pain. (*Circulation*, 2:344 [Sept.] 1950.)

Fromer reports successful treatment of chronic **lupus erythematosus**, both discoid and disseminated with **testosterone**. Daily doses of 20 mg. were given, and of 23 patients, 11 improved and 5 had complete remissions. Relapse occurred in 3 when the drug was stopped. (*Labey Clin. Bull.* 7:13 [July] 1950.)

**Chlorophyll** has proved to be useful in **deodorizing colostomies**. Goldman describes a gelatin capsule containing 60 mg. powdered chlorophyll and 360 mg. kaolin which is inserted into the colostomy each morning after evacuation. The capsules are manufactured by The Warren-Teed Products Company, Columbus, Ohio. (*Surgery* 28:550 [Sept.] 1950.)

**Thiomerin** is now probably the **mercurial diuretic** of choice since it is as effective as the others,

and is injectable subcutaneously. Recent work indicates that it may have greater toxicity in long-term administration. (Capp, R. T., et al., *Proc. Soc. Exp. Biol. & Med.* 74:511 [July] 1950.) A new diuretic, **Cumertilin** (Endo Products), is in the testing stage. It is a coumarin-mercurial compound, but has no anti-prothrombin effect. Comparison with Mercuhydrin showed a consistently greater diuresis after Cumertilin. (Shapiro, S., *J. Lab. & Clin. Med.* 36:224 [Aug.] 1950.)

**Streptokinase** and **streptodornase** are enzymes derived from cultures of streptococci. Streptokinase has lytic action on human fibrin, and streptodornase has the ability to liquefy the desoxyribose nucleoprotein which is liberated from the nuclei of leukocytes when the latter die. Such nucleoprotein may comprise 30 to 70 per cent of the solid matter in **empyema** pus.

Streptokinase has been given intrathecally with streptomycin to patients with **tuberculous meningitis** to prevent the fibrinous exudate which plugs up the basal cisterns. Both enzymes, when injected into a **hemothorax** or a loculated empyema, convert the contents to a liquid which is easy to aspirate. Surgical drainage and decortication are obviated. (Taylor, S., *Overseas Postgrad. Med. J.* 4:481 [July] 1950.)

**Intravenous procaine**, 10 cc. of a one per cent solution, is advocated as an office procedure by Shelanski (*Indust. Med. & Surg.* 19:427 [Sept.] 1950). He used it in 931 patients in a factory dispensary and significant relief was obtained in 75 per cent. Ailments ranged from pain due to **trauma**, and **itching dermatitis**, through **lead poisoning** and "flu."

C. A. DOMZALSKI, JR., M.D.

Help Fight TB



Buy  
Christmas Seals

# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*  
MISS KATHERINE NEWHALL, *Assistant Librarian*  
PHONE 6-5370  
8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.  
Monday through Friday  
Closed Saturdays at noon and Sundays  
Closed all day and evening on National holidays  
and at noon on Territorial holidays.

---

## RECENT ACQUISITIONS

### Anatomy and Physiology

- Anthony, C. P. *Textbook of anatomy and physiology*. 3rd ed. c1950. (gift of publisher)  
Tobin, C. E., ed. *Shearer's manual of human dissection*. 2nd ed. c1949. (gift of publisher)

### Cancer

- Ackerman, L. V. *Cancer: diagnosis, treatment and prognosis*. c1947. (from the Cancer Society)  
Rankin, F. W. *Cancer of the colon and rectum*. 2nd ed. c1950. (gift of publisher)

### Diagnosis

- Merck manual of diagnosis and therapy*. 8th ed. c1950. (gift of publisher)  
Pullen, R. S. *Medical diagnosis*. 2nd ed. c1950. (gift of publisher)  
Shanks, S. C. *A textbook of x-ray diagnosis*. v.4. 2nd ed. (gift of publisher)  
Warkentin, John. *Physician's handbook*. 6th ed. c1950. (gift of publisher)

### Glands

- Ralli, E. P., ed. *Adrenal cortex*. 1950. (gift of Josiah Macy, jr. Foundation)

### Gynecology and Obstetrics

- Curtin, A. H. *A textbook of gynecology*. 6th ed. c1950. (gift of publisher)  
Synder, F. F. *Obstetric analgesia and anesthesia*. c1949. (gift of publisher)  
Windle, W. F. *Asphyxia neonatorum*. c1950. (gift of publisher)

### History of Medicine

- Cumston, C. J. *An introduction to the history of medicine*. 1927. (gift of Dr. Frank Pleadwell)  
Dana, C. L. *The peaks of medical history*. c1926. (gift of Dr. Pleadwell)  
Neuberger, Max. *Essays in the history of medicine*. c1930. (gift of Dr. Frank Pleadwell)  
Park, Roswell. *An epitome of the history of medicine*. 2nd ed. c1899. (gift of Dr. Frank Pleadwell)  
Pilcher, L. S. *A list of books by some of the old masters of medicine and surgery . . .* 1918. (gift of Dr. Frank Pleadwell)  
Thaller, Lujo. *Od vraca i carobnjaka do modernog lijecnika*. 1938. (gift of Dr. Frank Pleadwell)

### Neurology and Psychiatry

- Association for Research in Nervous and Mental Diseases. *Multiple sclerosis and the demyelinating diseases*. c1950.  
Cattell, R. B. *Personality*. c1950. (gift of publisher)  
Cleckley, Hervey. *The mask of sanity*. 2nd ed. c1950. (gift of publisher)  
Fodor, Nandor, ed. *Freud: dictionary of psychoanalysis*. c1950. (gift of publisher)  
Foerster, Heinz von, ed. *Cybernetics*. 1950. (gift of Josiah Macy, jr. Foundation)  
Pohl, J. F. *Cerebral palsy*. c1950. (gift of publisher)

### Nursing

- Hetherington, H. W. *Nursing in prevention and control of tuberculosis*. 3rd ed. rev. c1950. (gift of publisher)

### Ophthalmology

- Callahan, Alston. *Surgery of the eye—injuries*. c1950. (gift of publisher)

### Orthopedics

- Luck, J. V. *Bone and joint diseases*. c1950. (gift of publisher)

### Pediatrics

- Mitchell, A. G. *Textbook of pediatrics*. 5th ed. c1950. (gift of publisher)

### Proctology

- Nesselrod, J. P. *Proctology in general practice*. c1950. (gift of publisher)

### Public Health

- Biological foundations of health education*. c1950. (gift of publisher)  
Hanlon, J. J. *Principles of public health administration*. c1950. (gift of publisher)

### Surgery

- Brophy, T. W. *Cleft lip and palate*. c1923. (gift of Dr. Van Poole)  
Evans, J. P. *Acute head injury*. c1950. (gift of publisher)  
Federspiel, M. N. *Harelip and cleft palate*. c1927. (gift of Dr. Van Poole)  
Smith, Ferris. *Plastic and reconstructive surgery*. c1950. (gift of publisher)

### Therapeutics

- Kovacs, Richard. *Light therapy*. c1950. (gift of publisher)

\* \* \*

The August 1950 issue of *Industrial Medicine and Surgery* devoted its pages almost entirely to a series of articles on Plantation Medicine by local doctors. Among those represented were **Drs. Nils P. Larsen, Wm. B. Pattersan, A. L. Dean, J. A. Burden, William H. Wilkinson, Leonard J. Goldwater, Edward C. Holmblad, P. H. Liljestrand, Harold Kushi, W. J. Halmes, Ralph B. Claward, Joseph E. Ferkany, and Harry L. Arnold, Jr.**



# BOOK REVIEWS

*Physician's Handbook.* By Marcus A. Krupp, M.D.; Norman J. Sweet, M.D.; Ernest Jawetz, Ph.D., M.D.; and Charles D. Armstrong, M.D. Sixth Edition. 380 pp. Price \$2.50. University Medical Publishers, Palo Alto, Calif., 1950.

The by now familiar Physician's Handbook has come out with the 6th Edition. It is still a handy pocket-sized reference book, but it has been extensively revised. The publishers have utilized the services of the younger brilliant minds in the San Francisco Bay area, and the result is commendable.

The table of contents is so indexed with black markers that with the flip of a finger the page the reader wants can be found.

The scope of the handbook continues to increase and the 6th Edition covers material from history taking through electrocardiography and radio-isotopes. The book has been much better organized than heretofore. The sequence of subjects follows a more rational and logical design for the reader.

All the old familiar tables with several new ones added are present and readily accessible. The diagrams and drawings are profuse for a book of this size and considerably enhance the understanding of the text.

I am personally very gratified to find a simplified section on electrocardiography in this edition. It will give the average practitioner who does not have either the time or inclination to study this field a chance to at least make a tentative diagnosis until an electrocardiogram interpreter can read the tracing. In the Territory this should be of real value to the doctors on plantations who are separated by distance from localities where there are men to read electrocardiograms.

I can heartily recommend this handbook for every practicing physician. The amount of material which a doctor is now expected to retain in his head has reached such voluminous proportions that a means of condensing this information must be available. Physician's Handbook is this means, and I personally would not be without one.

MORTON E. BERK, M.D.

*A Textbook of Gynecology.* By Arthur Hale Curtis, M.D., and John William Huffman, M.D. Sixth Edition. 799 pp. with 466 illustrations, chiefly by Tom Jones, including 37 in color. Price \$10.00. W. B. Saunders Company, Philadelphia and London, 1950.

This excellent book is most complete and thorough in its presentation of the entire subject of gynecology. It is well organized and the subject matter is clearly presented. A minimum of effort is required to obtain a concise and clear picture of the author's view on any gynecological problem.

The presentation of gross anatomy of the female pelvis is probably the best to be found in any book. That alone makes it a good investment for anyone interested in this field.

The physical properties of the book are good and in general this is the best text on the subject of gynecology with which I am familiar.

FRANK C. SPENCER, M.D.

*Textbook of Anatomy and Physiology.* By Catherine Parker Anthony, B.A., R.N. Third Edition. 614 pp. with 208 illustrations. Price \$4.00. C. V. Mosby Company, St. Louis, Mo., 1950.

The third edition of this text is larger than, yet very similar to, the previous edition, as to form, layout, and presentation of subject matter. Some material has been enlarged upon and others brought up to date.

The author writes as she teaches. Again and again the reader is reminded of a helpful teacher of long standing by a section heading "Some Facts to Remember"; or "... note the following"; or the page and a half devoted to "Hints on How to Learn Origins, Insertions, and Actions of Muscles."

The text is very concise. Of its 614 pages (which is small for a professional nursing students' text in Anatomy and Physiology these days) much space is devoted to 207 diagrams, photographs, introductory outlines, introductory vocabularies, 42 tables, 16 color plates, chapter summaries, chapter questions, and many incidental outlines scattered through the chapters. As a result of all this, there is not much descriptive matter in essay form. The author acknowledged that she is brief when she quoted an English proverb, "He teacheth ill that teacheth all."

The text is illustrated beautifully. Photography and drawings are shaded very clearly. Captions are distinct. This is an invaluable asset in an anatomy text.

The book is recommended as a quick reference text for the graduate nurse and a reference book for student nurses. It is an excellent guide for a beginning teacher and would be a big help as a text for a beginning teacher of anatomy and physiology.

BERTHA SCHIFFMAN, B.S., R.N.

*Obstetric Analgesia and Anesthesia, Their Effects upon Labor and the Child,* by Franklin F. Snyder, M.D. 401 pp., 114 figures, 18 tables. Price \$6.50. W. B. Saunders Company, Philadelphia and London, 1949.

In spite of all the advances made in the field of obstetric analgesia and anesthesia, we still do not have an ideal agent for the relief of pain in childbearing. This problem is a never ending one and a frequent topic for discussion.

This book is divided into two sections: the respiratory injuries of the child and the treatment of pain during labor.

In the first section Snyder discusses intrauterine respiration, intrauterine pneumonia, atelectasis and asphyxia. In his second section he deals with the various analgesic drugs, narcotic gases and local anesthetic agents. The discussion centers around the pharmacology of the various drugs, its effect on the mother and its effect on the child. Techniques in the administration of the various local anesthetic agents are touched upon rather lightly.

This book should appeal to the "scholarly-minded" physician for it is liberally illustrated with graphs and charts and also contains a good reference list. For those who are not so inclined, the summary at the end of each chapter covers the high points of the book and is worthwhile reading.

K. S. TOM, M.D.

WHO: *Annual Report of the Director-General to the World Health Assembly and to the United Nations, 1949*. Official Records of WHO, No. 24. Price \$0.75. Columbia University Press, New York, New York, 1950.

WHO: *Chronicle of the World Health*, Vol. 4, No. 5, May 1950. Price \$0.20. Columbia University Press, New York, New York.

The World Health Organization (WHO), an outgrowth of the League of Nations' Health Section, endeavors to raise levels of health throughout the world. Director-General Brock Chisholm's annual report reflects "the growing realization of governments that many health problems require for their effective solution, the united action of all nations." At the first health assembly in Geneva in 1948 and the second in Rome in 1949 "The programme was directed toward aiding governments in controlling and preventing disease, in coordinating and stimulating public health work and in strengthening public health administrations."

The report and the Chronicle contain the official statistics of WHO activities, administration, regionalization, finance, conferences, relationship with UN and other organizations and fellowship data. They well illustrate the importance of this organization in the world today and to every individual. Doctors, particularly, should be aware of its scope and tremendous value.

Any nation may join WHO upon the majority approval of the members. At present 68 nations comprise the membership. Regional offices in Asia, Mediterranean, Africa, Pacific, Europe and America control the projects undertaken, but they are coordinated from one place, Geneva. The central organization is responsible for the International Statistical Classification of Disease, Injuries and Causes of Death which has been accepted by 54 members. The expert committees involving epidemiology, health statistics, biological standardization, pharmacopoeias, habit forming drugs, environmental sanitation, malaria, tuberculosis, venereal disease, other diseases, maternal and child health, nutrition and mental health, represent experts from 34 countries.

Survey teams stand ready to go to any spot in the world to help local organizations to develop fuller programmes of health. At the request of the South Korean government, a maternal and child health team was appointed to advise on the organization of child centers.

What a picture we have as that nation, trying to help save its women and children, suddenly becomes the center of mass destruction of men, women and children. The nation which had refused to cooperate even in health matters decided it would rule this little nation by oppressive force, and the program of saving mothers and infants disappeared in the smoke of bombs. The world, through WHO, is trying to control malaria, tuberculosis and other infectious disease, and 68 nations have found that their citizens can get the best health protection only through world cooperation. It is working. Then why can they not cooperate with an international federation to outlaw war, which is our most destructive disease?

Dr. Chisholm says: "The close human relationships imposed by the modern social structure demand a higher degree than ever before of individual maturity and of social responsibility in its widest implications. The success of individuals and groups in achieving integration both within themselves and with one another will be essentially a measure of progress in 'mental and social well-being.' Failure may mean nothing less than the extinction of whole nations—perhaps of the race itself."

NILS P. LARSEN, M.D.

*Medical Diagnosis—Applied Physical Diagnosis*. Edited by Roscoe L. Pullen, M.D., F.A.C.P. Second Edition. 1119 pp. with 601 figures, 48 in color. Price \$12.50. W. B. Saunders Company, Philadelphia and London, 1950.

An excellent textbook for medical students, this book has little value for the practitioner except as a refresher. It tries to be all things to all doctors, and does not quite succeed. The sections on orthopedic and neurological examination are excellent, but other sections are cluttered up with obsolete irrelevancies, e.g., the "coin sign" in pneumothorax.

A peerless feature of the book is its consistent tying in of the use of various instruments which are normally used by any *thorough* examiner: the ophthalmoscope, proctoscope, vaginal speculum, etc. Normal and abnormal findings are amply illustrated. Some of the pictures are, however, a little mossy with age.

Examination of the breasts as outlined in 45 pages will occupy about one hour of assorted positions, perspectives and gymnastics. This would probably be enjoyable at times, often tedious, and always impractical.

C. A. DOMZALSKI, JR., M.D.

*New York Academy of Medicine: Biological Foundations of Health Education: Proceedings of the Eastern States Health Education Conference, April 1-2, 1948*. 169 pp. Price \$2.50. Columbia University Press, New York, 1950.

Don't be confused by the title! While this short book contains the papers presented at a health education conference, it is long on interesting recent developments in nutrition, psychiatry, gerontology, and epidemiology. It is a thought-provoking book. From it one can learn of the fascinating findings of modern nutrition as they relate to buoyant health, congenital defects, longevity, and gerontology. Psychiatry is presented in its relation to all of our daily lives, as is the increasingly interesting and important field of gerontology. The physician will be re-introduced to a broad concept of epidemiology which encompasses all of the factors and circumstances associated with the appearance of both communicable and non-communicable disease. The doctor will become more aware of the essential role he plays in health education. The philosophic physician will particularly enjoy several of the papers. It is good bedside reading.

This book has the advantage of being written by many eminent authorities. All of them write well and most of them interestingly.

This recent New York Academy of Medicine book can be recommended without reservation.

S. D. ALLISON, M.D.

*Nursing in Prevention and Control of Tuberculosis*. By H. W. Hetherington, M.D., M.R.C.P., and Fannie W. Eshleman, R.N., B.S. 361 pp. with illustrations. Revised Third Edition. Price \$4.50. G. P. Putnam's Sons, New York, 1950.

This is an excellent book to be used as a text or reference for the student or postgraduate nurse. It covers the subject of tuberculosis thoroughly including the medical, surgical, nursing technique and social aspects.

There is marked similarity between this and the 1945 edition. This edition is more valuable, however, since it contains discussion of the latest findings in the treatment and care of the tuberculosis patient. The use of the sulfones, streptomycin, para-aminosalicylic acid and BCG are briefly discussed, leaving the reader stimulated to seek additional information from other sources.

The many descriptive pictures, fairly large type, the individual subject headings, and the simple language used render this an especially good text for the reader.

ANGELA M. CARLUCCI, R.N., B.S., M.N.



*Personality.* By Raymond B. Cattell. First Edition. 689 pp. Price \$5.50. McGraw-Hill Book Company, New York, Toronto, 1950.

Written primarily as a text for students of psychology, many portions of this book will be of limited interest to medical practitioners.

However, a comprehensive study of factors in personality structure is presented, and impartial summaries of behaviorist and analytic approaches are included. Many interesting observations concerning psychopathology, based on statistical studies, are made.

Much of the book is preoccupied with a technical discussion of "precise personality measurements," including the technique of factor analysis. Attempts are made to study personality by means of complex mathematical equations, charts, and indexing. Whether this can be effectively done in an attempt to prove psychology a "science" is doubtful and not entirely necessary. The multiplicity of variables in human behavior, as well as the value of introspection in its study, should not be overlooked.

There is little mention of the contribution of projective techniques, and many highly debatable topics are presented as fact. The importance of hereditary factors in psychopathology is given considerable emphasis. This is challenged by many.

The differentiation of psychoses from neuroses, made by the author on the basis of insight, is not borne out by clinical experience.

KENNETH H. RUSCH, M.D.

*Cerebral Palsy.* By John F. Pohl, M.D. 224 pp. Price \$5.00. Bruce Publishing Co., Saint Paul, Minnesota, 1950.

Dr. Pohl offers in this small book a ready reference manual to the therapist working for the cerebral palsied child in techniques used at the Michael Dowling School for Crippled Children in Minneapolis, Minnesota, based on the study of the management of 512 cerebral palsied children.

Detailed methods of securing conscious relaxation both generally and for a specific muscle function are offered and should demand attention of the occupational, speech and physical therapist.

In the large section on "neuromuscular training" Dr. Pohl presents in detail with excellent illustrations methods of securing specific motor activities based on individual muscle function. This concept of treatment is subject to considerable discussion.

Little attention is paid to the difference in treatment principles in the various groups of cerebral palsied, i.e., spastic, athetoid, ataxic, etc. The differences in muscle tone, irritability, contractility, and the understanding of the "stretch reflexes" should be well understood by the therapist to insure success.

The sections on occupational and speech therapy are detailed and yet concise and offer many valuable suggestions to effective coordinated treatment.

The book is systematically organized and well written and should be of considerable value to the therapist working in cerebral palsy who realizes that treatment of these children is still in its infancy and that here, probably more than in any other field of rehabilitation, the success of treatment rests on individual evaluation and pliable application of modalities rather than routinized methods of training possible in the paraplegic or polio patient.

IVAR J. LARSEN, M.D.

*Principles of Public Health Administration.* By John J. Hanlon, M.S., M.D., M.P.H. 506 pp. with 48 illustrations. Price \$6.00. C. V. Mosby Company, St. Louis, Mo., 1950.

The philosophy of public health is presented in this book in a very readable manner. Those who are interested in public health as a profession should find it most helpful. It is especially recommended for physicians who either now are engaged in public health work or who may be interested in devoting full or part-time to public health and preventive medicine in the future.

The sections dealing with the basic and established public health programs in communicable disease control, environmental sanitation, collection and use of health statistics, public health nursing, etc., are well written and are brought up to date in these fields.

Health workers who are interested in geriatrics and the control of chronic diseases will find the sections of this book dealing with these subjects more complete than the presentations in most texts in this field. The parts dealing with the control of cancer and heart disease are especially well written.

Voluntary health agencies are discussed by this author in an objective manner. Their place in the overall health program is well delineated and the need for coordinating their activities with those of official health agencies is presented.

This book will be of value to all workers in public health—the physician, the nurse, the health educator, the social worker, the sanitarian, and all others who are interested in health promotion through official or private facilities.

WALTER B. QUISENBERRY, M.D.

*Human Sterilization.* By Robert L. Dickinson, M.D., and Clarence J. Gamble, M.D. 40 pp. Waverly Press, Inc.

This booklet is an excellent reference work on various methods of contraception and sterilization, as well as their legal aspects, particularly for the busy general practitioner, intern, medical student, and social worker or student in sociology. It gives brief but adequate descriptions for individuals of the foregoing category.

For the specialist in obstetrics and gynecology, the pamphlet is valuable mostly for its complete list of references, which total 355.

H. E. BOWLES, M.D.

*A Textbook of X-ray Diagnosis.* By British Authors in Four Volumes. Second Edition. Volume IV. 592 pp. with 553 illustrations. Price \$15.00. W. B. Saunders Company, Philadelphia and London, 1950.

This is an illustrated text designed for clinician and radiologist, with emphasis on common lesions encountered in diagnosis. Technical radiological aspects are minimized, with one exception: namely, the importance of standardizing positions for examination of an extremity or area. Introductory chapters review concisely normal osseous structure and variations of normal which are essential for accurate interpretation and comprehension of pathology. Remarkable is the correlation of anatomic, pathologic, radiologic and clinical aspects of inflammatory, benign and traumatic lesions. Sections on bone neoplasms are not comparable in presentation or scope to other available publications on the subject. Its classical text form provides an excellent and convenient reference but is not conducive to selective reading or leisurely perusal.

L. L. BUZAID, M.D.



*Shearer's Manual of Human Dissection.* Edited by Charles E. Tobin, Ph.D. Second Edition. 79 Illustrations, pp. 286. Price \$4.50. The Blakiston Company, Philadelphia 5, Pa., 1949.

A picture is worth a thousand words. However, a picture is generally restricted to showing *what*, while words are indispensable in telling *how*. This book tells *how* in the simplest possible language and appears to be a satisfactory adjunct to the study of human anatomy. It takes the student by the hand and leads him through the dissection of the human body in a step-by-step fashion. The illustrations cannot compare with standard anatomy texts or atlases, but they are quite adequate for the purposes of the manual. Human anatomy can be learned without a manual such as this, but this type of aid can be a definite help in the dissection of the human body.

ALVIN V. MAJOSKA, M.D.

*Proctology in General Practice.* By J. Peerman Nesselrod, B.S., M.S., M.Sc. (Med.), M.D., F.A.C.S., F.A.P.S. 276 pp. with 64 figures. Price \$6.00. W. B. Saunders Company, Philadelphia and London, 1950.

Dr. Nesselrod's text is the most useful source book on proctology for the general practitioner written to date. It supplies the essential information regarding the diagnosis and treatment of the common anorectal lesions along with emphasis logically placed on the visual examination of this area.

I believe his chapter on Anal Infection, Abscess, Fisture and Fistula is the finest recorded to date in any text. Further, the chapter on Anatomy and Physiology is well written, well illustrated and the surgical significance of the structures is clearly indicated. I was delighted to find a short chapter on Endoscopy of the Various Stomas, including ileostomy. To the best of my knowledge, this information has been noticeably lacking in the literature.

Although it is natural as well as an excellent gesture of respect for a student to give credit to, and reflect the principles of his teacher, it seems to me that Dr. Nesselrod may have leaned backward too far and has referred to Dr. Buie's teachings too frequently. However, these are the methods used by the author and for the most part one cannot go wrong by applying them. Many senior proctologists throughout the country, I am sure,

however, would assert that even *better* results might be attained by somewhat modified techniques in surgery of the anal canal, than by some of those cited by the author.

This book is not intended to be a source of all knowledge concerning the diseases and treatment of the lower gut and its outlet, but I believe that it fulfills the purpose for which it was written, i.e., to supply good fundamental and basic information regarding the common anorectal disease with pertinent emphasis on diagnostic procedures, and, of course, the early diagnosis of rectal and colonic cancer. It is prepared primarily for use in general practice and to this end I would unreservedly recommend Dr. Nesselrod's book.

V. C. WAITE, M.D.

*Plastic and Reconstructive Surgery—A Manual of Management.* By Ferris Smith, M.D., F.A.C.S. 895 pp. with 592 figures. Price \$15.00. W. B. Saunders Company, Philadelphia and London, 1950.

The title of the book describes its nature well, for it is truly a "Manual of Management." The illustrations and photographs are excellent. Ferris Smith is a master in the use of the principles of Z plastic, multiple excision, and interpolated flaps from the vicinity of the defect, and his results in this field are very good. Many photographs illustrate this fact.

For completeness of his text he has borrowed from other authors in allied specialties, but this does not detract from the book. His own cases are complete in his description of his procedures and are actually case reports of the various types of condition that fall in the realm of plastic and reconstructive surgery. It is a book worth having for anyone interested in this type of surgery.

WAYNE W. WONG, M.D.

*Asphyxia Neonatorum.* By William F. Windle, Ph.D., Sc.D. 70 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

This is a short book written in semi-outline form and well illustrated with drawings and charts.

The discussion of the subject is from the viewpoint of the physiologist rather than the practitioner. The subject matter is interesting to read but is mostly a summary of what is already well known. One of the best parts of the book is a good bibliography.

C. C. MCCORRISTON, M.D.

Nurse: Of course I'm not married, I'm nobody's fool.

Hopeful Young Medic: Then, will you be mine?



McARTHUR & SUMMERS

PRESCRIPTION • PHARMACISTS

PHONES 6-6044  
6-8865

THIRD FLOOR • YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 • 7-8411

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

A special dinner meeting of the Hawaii County Medical Society was held at the Naniloa Hotel on Wednesday evening, August 30, 1950. The guest speaker was **Dr. P. C. Jeans** of the Department of Pediatrics, State University of Iowa.

Guests present were **Dr. Pauline G. Stitt**, Chief, Bureau of Maternal and Child Health and Crippled Children of the Department of Health, Honolulu and **Dr. J. Warren White**, Chief Surgeon at the Shriners' Hospital of Honolulu.

The program began at 8:05 p.m. with **Dr. Bernstein** presiding. **Dr. Jeans** presented some of the newer concepts of prenatal diet based on his animal experiments. He also stressed the importance of infant and child nutrition.

Meeting adjourned at 9:45 p.m.

The 300th regular meeting (Semi-Annual) of the Hawaii County Medical Society was called to order by the President, **Dr. Leo Bernstein**, at 8:40 p.m. at the Honokaa Club, Honokaa, Hawaii on September 30, 1950. The hosts for the evening were the North Hilo, Hamakua and Kohala doctors. The following members were present: **Drs. Bernstein, Corter, Crawford, Fernondez, Hanlon, Kasamoto, Miyamoto, Mizuire, Okada, Okumoto, Seymour, Tomoguchi** and **Woo**. **Dr. Black** of Kamuela was a guest; and **Dr. J. Warren White**, Chief surgeon at Shriners' Hospital of Honolulu was the guest speaker.

**Dr. Okada**, chairman of the golf committee, presented the prizes to the golfers—**Drs. Tomoguchi, Carter** and **Okada**.

Due to a lack of a quorum, no official business was carried out.

The rest of the evening was turned over to **Dr. White** who presented a very instructive talk, with X-ray films and lantern slides, on the common fractures of the extremities. He also stressed the fact that nature, by bearing out Wolff's Law on bone healing, does improve to a great extent the badly deformed fractures.

The meeting adjourned at 10:45 p.m.

PETE T. OKUMOTO, M.D.  
*Secretary*

## HONOLULU COUNTY MEDICAL SOCIETY

The regular monthly meeting was held on Friday, September 1, 1950 at 7:30 p.m. in the Mabel Smyth Auditorium, with **Dr. Samuel Yee** presiding; about 80 members and guests were present.

**Dr. Yee** asked the members to stop in at the Medical Society office at their convenience to bring their procurement and assignment data up to date.

**Dr. Yee** announced that as of October 1, the Physician's Exchange will be able to offer twenty-four hour service. The rate will be \$8.50 per month for all doctors

who have been in practice for more than two years. A special rate of \$5.00 per month will be charged for doctors who are in practice less than two years. However, when the doctor has reached the two year limit, he will automatically be charged \$8.50 for the service. As the deadline for the listing in the telephone directory is September 15, the members were urged to stop at the exchange for information should they wish to obtain this excellent professional service.

The following program was presented:

"Strong and Weak Features of the Health Program in Hawaii of Special Concern to the Physicians" by **Dr. Iro V. Hiscock**.

"The Physician's Contribution to Public Health Statistics" by **Dr. Halbert L. Dunn**, Chief of the National Office of Vital Statistics, United States Public Health Service.

"Some Observations on Carcinoma of the Stomach in Hawaii" by **Dr. J. E. Strode**.

"The New HMSA Policy and Procedure Methods" by **Dr. Robert B. Faus**.

After the program, refreshments were served in the lanai.

The society's regular October meeting was held October 6 in the Mabel Smyth Building, with **Dr. Yee** presiding; about 103 members and guests were present.

**Dr. Arnold, Jr.**, and **Dr. Hartwell** both urged the members to give generously to the Community Chest.

**Dr. Berk** announced that the Board of Governors had approved of the drive for detection of diabetes, which will commence in the near future, and asked for the cooperation of the members.

**Dr. Faus** reported on procurement and assignment. He stated that October 16 has been set as the registration date of physicians who come under Priorities 1 and 2 of Public Law 779.

The following program followed:

Movie: Medical Aspects of the Atomic Bomb, Part I, *Physical Destruction, Casualty Effects*.

"Prolapsing Redundant Gastric Mucosa" by **Dr. Peter J. Washko**.

"Management of Premature Infants—Report from the Premature Institute, Cornell University," by **Dr. Clifford Koboyoshi**.

"Observations in European Hospitals and Clinics," by **Dr. Wm. J. Holmes**.

Following the meeting, refreshments were served in the lanai.

WM. M. WALSH, M.D.  
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The monthly meeting of the Kauai County Medical Society was called to order by **Dr. Goodhue** at 7:30 p.m. Wednesday, Aug. 9, 1950 at Wilcox Memorial Hospital Library. Guests were **Drs. R. B. Faus, H. L. Arnold, Jr.**, and **Mr. O. B. Patterson**.

A letter was read from **Dr. Richert** of the Honolulu County Medical Society pertaining to a proposed change in the present Workmen's Compensation Law. It was moved by **Dr. Wallis**, seconded by **Dr. Beiber** that this County be in favor of the present law due to the plantation health system.

The second topic to be discussed was a formation of the grievance committee to handle disputed problems between the physicians and H.M.S.A. **Drs. Wade, Masunaga, and Wallis** were appointed to this committee.

The next problem to be discussed dealt with the appointment of a Medical Director from Kauai for the Territorial Major Disaster Council. **Dr. Kemp** was appointed to this post.

**Dr. Wallis** then announced that the Territorial Association of Plantation Physicians would meet here in Kauai on November 9, 10, 11, 12. The Kauai County Medical Society went on record as endorsing this meeting.

The financial statement was then read by the treasurer for the Kauai County Medical Society and the standing balance was noted to be \$93.45 not including \$110.00 of the Mental Hygiene fund.

The monthly meeting of the Kauai County Medical Society was called to order by **Dr. Goodhue**, 7:30 p.m., Wednesday, September 13, 1950 at the Wilcox Memorial Hospital library. **Dr. R. B. Cloward** was a guest.

**Dr. Goodhue** reported a message from Mr. Ehlers concerning Red Cross activity in case of disaster. He asked that the different localities be represented at a meeting in the future by one or more doctors. **Dr. Boyden** then made a motion that **Dr. Wade** should represent the disaster council at the meeting on September 20, 9:30 p.m.

**Dr. Kemp** made a report on her disaster council to which she appointed the following physicians: **Dr. Cockett**, in charge of emergency medical care and ambulance; **Dr. Wallis**, in charge of hospitalization; **Dr. Steuermann**, in charge of inspection of evacuation centers.

The meeting was then adjourned at 9:30 p.m. Directly following, **Dr. Cloward** gave a brief talk on the Diagnosis and Treatment of Emergency Head Injuries.

KEITH KUHLMAN, M.D., *Secretary*

## MAUI COUNTY MEDICAL SOCIETY

A regular dinner meeting of the Maui County Medical Society was held at the Maui Grand Hotel on August 15, 1950 at 6:15 p.m. with **Dr. Cole** presiding. **Drs. Pauline Stitt and Dorian Paskowitz**, of Honolulu, were guests.

### Finances:

Cash in Bank as of June 20, 1950.....	\$ 957.25
Receipt from Society and AMA Dues.....	850.00
Expenditures	
Miscellaneous .....	\$ 14.00
Territorial Association Dues and Journal.....	783.00
Balance as of August 15, 1950.....	\$1,010.25

A letter from **Dr. Tompkins** of Kula pertaining to the availability of a pathologist on part-time services was read. **Dr. Ferkany**, Society's representative to Hawaii Cancer Society, added that since **Dr. Tompkins'** communication, the Cancer Society agreed to underwrite \$6,000 of the proposed \$12,000 annual basic salary of a resident pathologist for Maui for two years. **Dr. Cole** injected into the subject at the suggestion of **Dr. Rockett**, who

was not present at the meeting, that a resident roentgenologist for Maui was more in line with the Society's need at this time. A discussion followed particularly on the matter of the financial managements to raise the necessary \$6,000 among the membership.

It was moved by **Dr. McArthur**, seconded by **Dr. Burden** and carried that the Society go on record as approving the fine gesture and cooperation of the Cancer Society in the matter of a resident pathologist for Maui. **Dr. Cole** appointed **Dr. Ferkany** as the Chairman of Pathologist Committee to study further the possibility and practicability of obtaining a resident pathologist.

A letter from **Dr. Arnold, Jr.**, of the Honolulu County Medical Society, requesting the opinion of the Society regarding the free choice of physician by the employee instead of by the employer under the present Workmen's Compensation Act, was brought to the attention of the membership for consideration. In the lengthy discussion that followed, the plantation physicians employed by management to take care of their own industrial accidents questioned the inclusiveness and implications of such a change in the legislation.

**Dr. Fleming** moved that the Society approve the change in the Workmen's Compensation Act. The motion was seconded by **Dr. Tofukuji**.

**Dr. Underwood** moved to table **Dr. Fleming's** motion for consideration at a later meeting. The motion was seconded by **Dr. Wong** and passed.

It was further voted to mail a copy of **Dr. Arnold's** letter with the minutes of the meeting to each member of the Society for his perusal.

The membership accepted **Dr. Molloy's** resignation from the Society effective as of June 30, 1950.

It was unanimously agreed to accept the invitation of **Mr. Tam**, Chairman and Executive Officer, County of Maui, to participate in the ground breaking ceremony of the Central Maui Memorial Hospital on August 20, 1950. About 16 members including their wives promised to be present at the ceremony.

The film entitled "Self Examination of Breast" put out by the American Cancer Society was shown to the membership. The film was approved for circulation to the lay organizations.

**Dr. Paskowitz** spoke briefly on cancer, particularly of the breast, illustrating with lantern slides, the incidence and relationship of cancer in various races in Hawaii.

A special breakfast meeting of the Maui County Medical Society was held at the Puunene Club House at 8 a.m. on September 3, 1950 with **Dr. Cole** presiding. **Dr. P. C. Jeans**, head of the Department of Pediatrics, State University of Iowa, and **Dr. Clifford Kobayashi**, Honolulu, were guests.

A letter from **Mrs. J. Garner Anthony**, Chairman of the Territorial Commission on Children and Youth, was read asking the cooperation of the medical society in backing it up.

A letter from **Dr. V. C. Waite**, Program Chairman of the Honolulu Surgical Society, was read inviting any member of this society to attend their meeting on September 22 at the Mabel Smyth Building, Honolulu.

The meeting was turned over to **Dr. Jeans**, who spoke on nutrition in children.

EDWARD KUSHI, M.D.  
*Secretary Pro-tem.*



A regular dinner meeting of the Maui County Medical Society was held at Kula Sanatorium on September 19, 1950 at 6:30 p.m. with Dr. Cole presiding. Dr. V. Boido, of Kula Sanatorium, was a guest.

**Dr. Ferkany** spoke on cancer of the lung.

It was moved by **Dr. McArthur**, seconded by **Dr. Wilkinson**, that **Dr. Fleming's** motion made at the previous meeting approving the change in the Workmen's Compensation Act be tabled indefinitely. Passed with one dissenting vote. The secretary was also instructed to write to Dr. Arnold, Jr., stating that the proposition does not involve our local set-up and that the membership does not desire at this time to express our feeling either for or against this particular matter.

**Dr. Toney** announced that **Dr. Sam Wallis**, President of the Territorial Association of Plantation Physicians has invited the members to attend its annual meeting in Lihue, Kauai sometime in November 1950. He also stated that Dr. Wallis would welcome papers and suggestions by society members.

**Dr. Ferkany** of the Pathologist Committee reported on the financial quota agreed upon by the hospitals on Maui. The division of the expenses matching the \$6,000 underwritten by the Cancer Society is as follows:

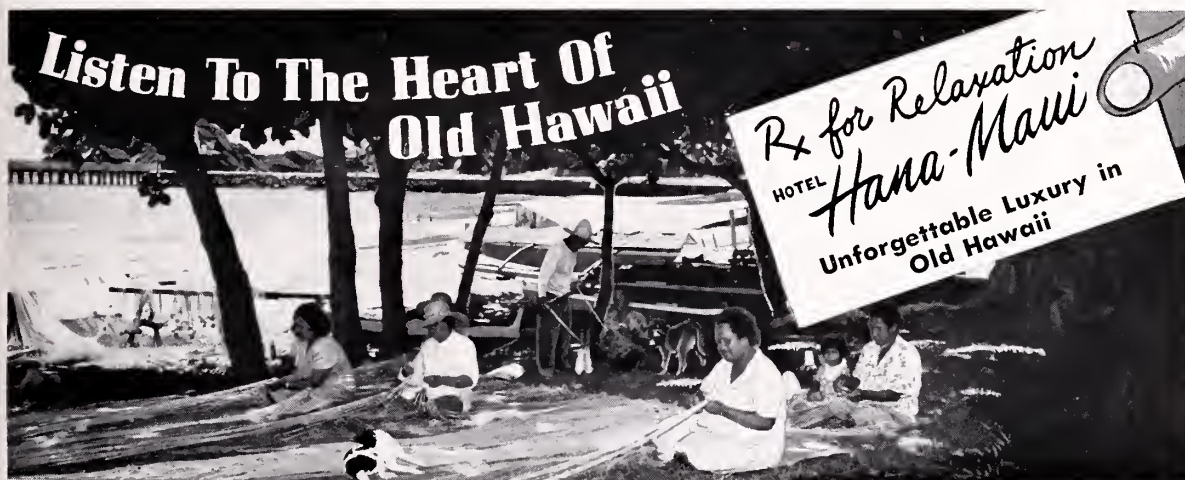
Malulani Hospital.....	\$200 per month to \$2400 per year
Puunene Hospital.....	175 per month to 2100 per year
Kula Sanitarium.....	100 per month to 1200 per year
Pioneer Mill Co. Hospital.....	25 per month to 300 per year

A short discussion followed concerning the best possible methods of procuring a qualified resident pathologist for Maui. It was agreed that the president appoint a committee for such a purpose.

**Dr. Johnson's** resignation from the Society, effective as of June 30, 1950, was accepted.

According to **Dr. McArthur**, medical member of the Maui Chapter of the National Foundation for Infantile Paralysis, a one year physical therapy scholarship has been made available to any qualified candidate on Maui.

EDWARD T. SHIMOKAWA, M.D.  
*Secretary*



At Hana, Maui, you'll be in another world, where centuries stand still. There you'll come upon the luxury of beautiful Hotel Hana-Maui, hidden deep in the legend-haunted grounds of Hana. There where old Hawaii lives on, you'll find superb food, accommodations and recreational facilities—all the things you like to do . . . and all the time in the world to do nothing!

Bask in the balmy breezes that rustle jungle foliage over tranquil Hana Harbor. Leave

your cares and worries behind . . . and head for Hana, Maui!

Honolulu Reservations Office:  
Outrigger Arcade — Phone 90-0355

HOTEL *Hana-Maui*

**NOW OPEN—  
HANA'S OWN AIRPORT**

# NOTES AND NEWS

## PERSONALS

Kuakini Hospital announces the addition to its staff of residents of **Dr. Chrysanthia Kubota**, a native of San Francisco, California. Dr. Kubota is a graduate of Women's Medical College, 1949 and served an internship in the Methodist Hospital in Philadelphia, Pennsylvania. She came to Kuakini Hospital in August, 1950.

Leahi Hospital announces the addition to its staff of **Dr. James A. Mitchel**. Dr. Mitchel is on the surgical service and is assistant to Dr. Gebauer. Dr. Mitchel went to Leahi Hospital after completing his surgical residency at Queen's Hospital. **Dr. Brooke Jamieson** has rejoined the staff of Leahi Hospital as senior resident physician after an absence of one year spent in pursuing post-graduate work in internal medicine at the Los Angeles County Hospital. While away Dr. Jamieson was co-author of a paper on thyroid diseases which will appear in the *Journal of Endocrinology*.

**Dr. Ralph B. Cloward** has recently returned from the mainland where he attended the meeting of the American Academy of Cerebral Palsy in Chicago and the American College of Surgeons meeting in Boston plus the meeting of the International College of Surgeons in Cleveland.

**Dr. R. O. Brown** is presently on the mainland for a two months trip, returning the first of the year. Dr. Brown will spend a good deal of time at the Mayo Clinic in Rochester, Minnesota.

**Dr. Tell Nelson** has recently returned from a mainland trip where he attended meetings of the Academy of Otolaryngology and Ophthalmology at Chicago. Dr. Nelson also visited allergy clinics in New York and Chicago.

**Dr. Ezra Austin** on a recent mainland trip attended the meetings of the Academy of Otolaryngology and Ophthalmology in Chicago and the convention of the International College of Surgeons in Cleveland. The second part of his trip was occupied with visiting relatives in Kentucky and Philadelphia.

A highlight of **Dr. Joseph Palma's** recent mainland trip was the attendance at his 30th class reunion which was held in conjunction with the 100th anniversary of the medical school at the University of Michigan. Out of sixty-five survivors of his class, forty-two showed up for the reunion. Most of the members of his band, which was a prominent extracurricular activity in medical school, were there at the reunion and renewed old times by having a jam session. Dr. Palma also attended the meetings of the American Academy of Pediatrics in Chicago, of which he is the state chairman for Hawaii.

**Dr. Louise Childs** has resumed practice on a part-time basis at The Clinic.

**Dr. F. J. Pinkerton** on a recent mainland trip attended meetings of the American Academy of Otolaryngology and Ophthalmology in Chicago and attended the meetings of the American Association of Blood Banks at the Stevens Hotel in Chicago. Dr. Pinkerton went on to Washington, D. C., where he conferred with individuals in the Bureau of Medical Services for the Army, a subdivision of the office of Secretary of Defense.

**Dr. Laurence M. Wiig** of Honolulu has returned from attending the annual reunion of the Alumni Association of the Mayo Foundation, Rochester, Minnesota. He also attended the meetings of the American College of Surgeons in Boston. Dr. Wiig spent two weeks on the west coast visiting hospitals and surgical clinics and returned with Mrs. Wiig on November 11 on the Lurline.

**Dr. Donald Marshall** on a recent mainland trip visited medical centers in the east. Dr. Marshall reports on his first parachute jump made at Coney Island.

**Dr. Philip M. Corboy** has returned from a recent trip to the mainland where he attended meetings of the American Academy of Otolaryngology and Ophthalmology in Chicago. He also attended the CAA medical meeting in Oklahoma City. The remainder of his mainland trip was spent fishing in Acapulco, Mexico.

**Dr. Samuel Yee** recently attended the American College of Surgeons meeting in Boston followed by a week in New York City and a week in Chicago visiting friends and various hospitals.

**Dr. and Mrs. Carl Johnsen** became the parents of their third son, Carl Kalani, on October 6, 1950. Dr. Johnsen is the anesthesiologist at St. Francis Hospital.

An important event in the Medical Group recently was the marriage of **Doris Larsen** to **Dr. John Frazer**. Mrs. Frazer is the niece of **Dr. Nils P. Larsen** and secretary of the H.S.P.A. Dr. Frazer is head of the E.E.N.T. department of the Medical Group.

Another wedding of interest to those in medical circles occurred in August, with the marriage of **Dr. Cora Mae Lee** to **Dr. Francis T. C. Au**. Both are graduates of Jefferson Medical College in Philadelphia and both are with The Queen's Hospital.

**Drs. Isami Umaki, Thomas F. Fujiwara and Roy T. Tanoue** have announced the opening of their new offices at the Central Medical Building on Beretania Street.

**Dr. L. T. Chun** has entered private practice opening his offices in the King Kalakaua Bldg. specializing in pediatrics. Dr. Chun graduated in 1936 from the Hilo high school and in 1940 from the University of Hawaii. After graduating from the Jefferson Medical College in Philadelphia in January 1944, he interned at Lankenau Hospital in that city. He spent the period of 1944-1946 in the army. Since 1947 he has been training in pediatrics in Philadelphia, devoting a year to a general rotating residency, and six months each to residencies in contagious diseases, clinical work and rheumatic fever and new born service. He returned to Hawaii in July, 1949 to become chief resident at the Kauaikeolani Children's Hospital for one year ending this past July.

**Dr. Albert Ishii** has announced the opening of his offices in the Medical Arts Bldg. for the practice of internal medicine.

**Dr. James T. S. Wong** has recently announced the opening of his office, marking his first entry into private practice in Honolulu in the specialty of obstetrics and gynecology. Dr. Wong is a native of Olaa, Hawaii and a graduate of the University of Hawaii and Jefferson Medical College in Philadelphia. Following an internship at Queen's Hospital he entered the Army Medical



Corps. Following discharge from the army he returned to Queen's Hospital where he completed a residency in obstetrics and gynecology. Following this Dr. Wong spent a year in Philadelphia, completing his post-graduate training in obstetrics and gynecology at the Jefferson Medical College Hospital, from which he has just recently returned.

**Dr. Jahn W. Cooper** returned in September after a two months' mainland trip featured by extensive touring throughout the mainland visiting all the national parks and reaching into Canada where many of the famous scenic spots were visited. Dr. Cooper and members of his family did their touring in a house trailer and found it a very exciting, interesting and satisfactory way to travel into the far corners and to points of scenic interest on the mainland. Dr. Cooper attended the polio seminar at Stanford, the A.M.A. convention in San Francisco in June and visited numerous orthopedic clinics on the west coast. One highlight of the trip was salmon fishing in the Columbia river and Pacific Ocean.

**Dr. H. F. Moffat** was on the mainland in October, attending the meeting of the American Academy of Otolaryngology and Ophthalmology in Chicago, following which Dr. Moffat went to Toronto where he remained for ten days visiting the eye clinics there.

**Dr. Raymond C. Yap** returned in October from a brief visit to the mainland, spent for the most part in Canada visiting the scenic spots of northwest Canada and attending the meetings of the British Columbia Medical Society the latter part of September.

**Dr. Clarence E. Frank** has returned just recently from a mainland trip marked by attendance at the meeting of the International College of Surgeons in Cleveland, the American College of Surgeons in Boston and a conference in New York of insurance company medical examiners. Dr. Frank also visited Mexico.

**Dr. Agnes P. McGavin** has recently arrived in Honolulu to assume the position of child psychiatrist with the bureau of mental hygiene. Dr. McGavin received her pre-medical and early medical education at the University of Glasgow in Scotland and her M.D. degree from the University of Toronto in Canada. Following this she took advanced post-graduate work at Columbia University in the field of child development and abnormal psychology. Prior to coming here Dr. McGavin was head of the McGavin school for child study in Buffalo, New York for ten years.

**Maj. George W. Martin** of the Tripler General Hospital staff made a recent trip to Japan concerning the Korean war casualty situation.

### GUY CHAMPION MILNOR, M.D.

1887-1950

A beloved family doctor and respected specialist were both lost to Honolulu by the death, on October 26, of Dr. Guy C. Milnor. Few physicians achieve such a remarkable combination of their colleagues' professional esteem, their patients' respect and devotion, and their friends' admiration and affection, as Dr. Milnor did. All were deeply shocked by his untimely loss, which occurred as a result of an intraventricular hemorrhage sustained only three days before. Surviving are his widow, Mrs. Nell Poersel Milnor, and their son, Dr. John C. Milnor.

Dr. Milnor was born in Warrenton, Pennsylvania, on January 31, 1887, the son of Dr. Mahlon T. and Ada (Champion) Milnor, and as a boy he helped his father carry on general practice in and around this town of approximately 200 people. He graduated from the University of Pennsylvania Medical School, where he had joined the Alpha Kappa Kappa medical fraternity, in 1914, and came to Honolulu to interne at The Queen's Hospital in the same year. On the day he arrived he was required to help Dr. James Judd start a laparotomy; but land-sickness intervened and Dr. Judd had to finish the operation unassisted.

Following his internship he served as plantation physician at Puunene, Maui, for 5 months. There he met Nell Poersel, whom he married in Seattle the following January 16. Following his marriage, he and Mrs. Milnor returned to Honolulu, where he went into practice with Dr. George Straub and became, three years later, the original partner in The Clinic. He specialized, and the organization was formed, in obstetrics and gynecology; but he never turned away an old patient

and never, despite his specialization, stopped being a family doctor.

In 1918 Dr. Milnor attended the Army Medical School and served in the Army Medical Corps for nearly a year in World War I, returning to Hawaii with Mrs. Milnor in 1919. On August 11, 1920, their son John was born.

Dr. Milnor was a Fellow of the American Medical Association and the American College of Surgeons; he was a Mason and a Shriner. He was President of the Honolulu County Medical Society in 1926 and of the Hawaii Territorial Medical Association in 1935. From 1934 to 1938 he was a member of the Territorial Board of Health, and he also had served as a member of the Territorial Board of Medical Examiners and, in World War II, a member of the Selective Service Appeal Board. He played an important part in the evolution, and was the original and only medical member of the Board of Trustees, of the Kapiolani Maternity and Gynecological Hospital. He was an actively participating member of both the Oahu Country Club and the Outrigger Canoe Club. He made frequent contributions to obstetrical and gynecologic medical literature, chiefly in the form of instructive case reports. He was loved by a multitude of friends as a golfing companion and one of the most genial of hosts. Saddened as we are by his loss, we can remember, in the words of Robert Louis Stevenson, that

... of human days he lived the better part.  
April came to bloom, and never dim December  
Breathed its killing chills upon the head or heart.

H. L. A., JR.



**Col. John H. King, Jr.** of Tripler General Hospital on a recent mainland trip presented a paper before the Academy of Otolaryngology and Ophthalmology in Chicago.

**Dr. Samuel D. Allison** has recently been certified by the American Board of Dermatology and Syphilology.

Leahi Hospital lost a member of its medical staff when **Dr. Germaine A. Guntzer** died of a cerebral hemorrhage on September 2. Dr. Guntzer was born in Port Chester, N. Y. in 1899. She was graduated from Cornell University Medical College in 1931. Following an internship, she was a resident on the tuberculosis service at Grasslands Hospital, White Plains, N. Y. She was awarded a degree in Public Health by Yale University in 1941. During the war she worked as an army doctor at Fort Monmouth, N. J. Following a period of service with the National Tuberculosis Association in New York, she joined the staff of Leahi Hospital as a resident in 1947. Dr. Guntzer was a member of the American Trudeau Society. She is survived by her brother, Vincent Guntzer of Honolulu.

**Dr. W. John Holmes** has recently been invited to write abstracts for the Ophthalmology Section of *Excerpta Medica*. Three other doctors in Hawaii also abstract articles for *Excerpta Medica*: **Dr. Harry L. Arnold, Jr.** for the Dermatology Section, and **Dr. Steele Stewart** and **Dr. Wayne Wong** for the Surgery Section. If other physicians in Hawaii are performing this service, we would like to know about it.

## Hawaii

### New Faces

**Dr. Richard W. Neil**, formerly of Aiea, is now assisting **Dr. John Milford** as assistant plantation physician of the Olaa Sugar Company. He is filling a vacancy caused by the resignation of **Dr. Donald Depp** who is now practicing privately in Honolulu. Dr. Neil is a graduate of University of Chicago School of Medicine, Chicago, Ill.

**Dr. Hiei Higa** recently started his private practice in Hilo. He was formerly associated with **Dr. Z. Matayoshi** at the Matayoshi Hospital in Hilo. Dr. Higa is a graduate of Tokyo Jikei Medical School, Tokyo, Japan.

### Future Doctor

**Dr. and Mrs. Kay K. Ota** took it upon themselves to become father and mother to a seven pound six ounce baby boy on August 31, 1950. By this time, the youngster must be well on his way to become a future emcee. Incidentally, papa Ota is quite the busy man these days. During the day, he takes care of **Dr. M. H. Chang's** and **Dr. R. P. Wipperman's** practices; and during the night, he takes his turn at humoring Junior.

### Absentees

**Dr. S. R. Brown** is still in the states vacationing.

**Dr. M. H. Chang** is also in the states holoholoing.

**Dr. T. Ota**, ditto.

**Dr. R. P. Wipperman** is taking a two months course at the Medical Field Service School in Texas as a member of the Medical Corps of the local national guard.

### Wanted

Doctors are badly needed at Naalehu and at Kealahou, Kona. If anyone is interested in practicing at any of these places, please contact the secretary of the Hawaii County Medical Society.

## Maui

**Dr. and Mrs. William Dunn** of Lahaina returned from their mainland trip.

A daughter was born to **Dr. and Mrs. Harold Kushi** of Wailuku.

**Dr. and Mrs. John Sanders** went to the mainland for their vacation.

**Dr. Earle J. Meuli**, who completed interne training at Queen's Hospital, Honolulu, has replaced **Dr. J. E. Molloy** at his position in Maunaloa, Molokai. **Dr. Molloy** is at present taking 2 years residency training at All Saint's Hospital, Fort Worth, Texas.

**Dr. Jesse Knox**, who recently completed interne training at Queen's Hospital, Honolulu, is now associated with **Dr. William Wilkinson** at Lanai City. He replaces **Dr. Elmer C. Johnson** who is taking residency training in internal medicine at Hines Veterans Hospital in Chicago, Ill.

**Dr. V. Boido** is the new junior resident physician of Kula Sanatorium, Waiakoa, Maui.

**Dr. J. Fleming** of Wailuku is doing locum tenens work in a missionary hospital in Assam, India, near the scene of the recent earthquake disaster.

## NEWS

### Tuberculosis Studies and Workshop

Studies which should be of much interest and value to the medical profession as well as to the public in general are being undertaken by the Oahu Tuberculosis and Health Association.

The first study, now nearing completion, is a statistical analysis of cases found in the first community-wide X-ray survey in 1947, and their subsequent progress. Statistical studies on other phases of the tuberculosis problem in Hawaii are planned for the next year. The work is being done by Miss Adele Schlosser, who is on a leave of absence from the National Tuberculosis Association.

The study is one phase of the work carried on by the tuberculosis association with funds derived from the sale of Christmas Seals.

During the last year, the association's rehabilitation work has been expanded, and the shop, christened Lanakila Crafts, is able to care for a larger number of discharged tuberculosis patients. All admissions to the workshop are on advice of the individual's physician, whose recommendations also govern all activities of ex-patients at the workshop, including the number of hours worked and type of work done. Ex-patients are eligible for discharge when they have reached a maximum work tolerance of eight hours daily in the opinion of their physicians. Workers may be retained in the workshop for longer periods, if necessary for social adjustment, job placement, development of projects, financial aid, or other reasons.

The shop is in the association's building at 1700 Lanakila Ave., above School St., and is open to the public from 8 a.m. to 4 p.m.

The association's work also includes health education and assistance to chest X-ray surveys, both of which have been projects for many years.

Offices in Young Building, completely equipped for general practitioner, for sale or rent. For information phone 5-6893.



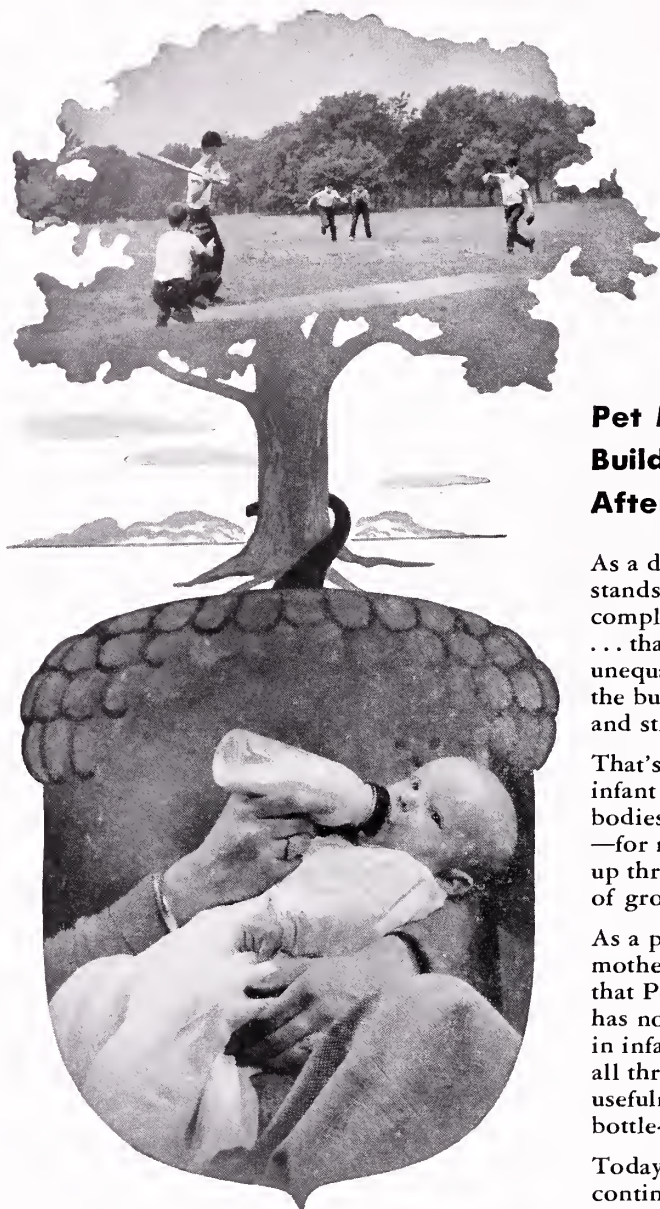
*"A high percentage of cases of seasickness and carsickness can be aborted or prevented by suitable doses of dimenhydrinate (Dramamine)."*

—Council on Pharmacy and Chemistry, New and Nonofficial Remedies, J.A.M.A. 143:815 (July 1) 1950.

**DRAMAMINE<sup>®</sup>** Brand of Dimenhydrinate—for the prevention or treatment of motion sickness—is supplied in 50 mg. tablets and in liquid form.



RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**



**Favored Form  
of Milk for  
Infant Formula**



### **Pet Milk Helps Build Sturdy Bodies... After Weaning, Too!**

As a doctor you know that milk stands alone among foods in its completeness of nutritive content . . . that milk, therefore, is unequaled by any other food for the building of sturdy bodies and strong, straight teeth.

That's why you recommend it for infant feeding! That's why young bodies need milk continuously—for muscles, bones and teeth—up through the strenuous years of growth.

As a physician you know what a mother sometimes fails to realize, that Pet Evaporated Milk, that has nourished her child so well in infancy, is good milk to drink all through life . . . that its usefulness extends far beyond bottle-feeding days!

Today, thousands of children are continuing to thrive on Pet Milk long after weaning from bottle to cup. The same qualities recommend it—unfailing sterility, easy digestibility, retention of food values, economy!

So when mothers ask that familiar question, "When do I change my baby to regular milk?," the wise answer is "Pet Milk *is* milk—safe, convenient, economical milk! Keep your child on it through *all* his growing years!"

**PET MILK COMPANY, 1424-K Arcade Building, St. Louis 1, Missouri**



# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

## BULLETIN COMMITTEE

VIOLET BUCHANAN, *Editor*, Leahi Hospital, Honolulu  
ALISON MCBRIDE, *Territorial Association Secretary*, Honolulu  
MYRTLE SCHATTENBURG, *Chairman, Nursing Information Committee*, Honolulu  
MABELCLAIRE NORMAN, *Executive Secretary*, Honolulu

### *Secretaries*

BESS HAMMER, Hawaii  
VIRGINIA RAUTENBERG, Honolulu  
PAULINE JOHNSON, Kauai  
LAURA WONG, Maui

### *Publicity Chairmen*

GRACE LUSBY, Hawaii  
HELEN GAGE, Kauai  
EILEEN MACHENRY, Maui

## PLATFORM FOR THE NURSES' ASSOCIATION, TERRITORY OF HAWAII 1950-1951

(Adopted from the Platform for the American Nurses' Association for 1950-1951)

### **Providing Health Protection for the People of the Territory**

1. Participate actively with allied groups to meet the health needs of the Territory and particularly the need for nursing care.
2. Appoint a committee to follow and report the progress made by the American Nurses' Association in establishing National Organizational structure for effective action in nursing.
3. Continue to plan with the Territorial Disaster Committee for care in time of emergency.
4. Promote prepaid health and medical care plans, encouraging them to include nursing.
5. Support accreditation of programs in nursing education by the profession to protect the student nurse and the public.
6. Increase the supply of competent nursing personnel through such measures as continued interest in providing a better prepared recruitment program for students and continued active participation in Counseling and Placement.

### **Aiding Nurses to Become More Effective and More Secure Members of Their Profession**

7. Promote Federal, Territorial and local financial aid for the improvement of schools of nursing for scholarship aid and for research in nursing.
8. Improve working conditions which directly affect the recruitment and efficiency of nursing personnel through strengthening economic security programs, using group techniques including collective bargaining, and supporting desirable labor legislation affecting nurses.
9. Promote a wider use by nurses themselves of voluntary insurance plans and support the extension of Federal Social Security to all nurses.

### **Achieving Better Health Care for the Peoples of the World**

10. Promote international exchange of students and teachers of nursing, and support programs for displaced persons in the nursing profession.

11. Cooperate in the development of Professional Nursing in the Americas.
12. Support the United Nations and its specialized agencies, particularly the World Health Organization, through the International Council of Nurses.

## HOW YOUR DELEGATES VOTED AT THE CONVENTION

1. Accepted the Platform for NATH after that presented by ANA at the Biennial in June 1950.
2. Accepted revisions of the constitution as presented by Mrs. Mabel Snyder, Chairman of the Constitution and By-Laws Committee, to coincide with revisions of ANA constitution. District Associations and NATH will now be able to offer associate membership for the first time. This will permit properly qualified nurses not employed more than 30 days during the year to become members of ANA through their local associations at greatly reduced dues. NATH associate member dues have been set at \$2.75 per year, 75 cents of this to be paid to ANA. Local associations will have to decide upon any additional dues they feel indicated. Associate members will not have voting privileges nor be able to hold office or committee chairmanship, but they can serve on special committees and participate in social and educational functions of the association.
3. Authorized the Board of Directors to initiate such activity as may be necessary to assist in making the Social Security Act effective for all voluntary hospital employees.
4. Agreed to contribute \$1.00 per active member per year for the ensuing five years toward the special research project fund of ANA to determine the functions of members of the health team as a means of improving nursing services. District associations are to be held responsible for obtaining this contribution from their members.
5. Asked the Board of Directors of NATH to assume immediate leadership in the implementation of an economic security program for the membership of the association and to take all the necessary steps in the establishment and forwarding of such a program.

6. Agreed to request the local associations to form a Relief Committee to function in case of a disaster. Such committees will aid the local disaster committees in the instruction of nurses and civil population in the principles of home nursing and first aid, working in cooperation with the Red Cross, and coordinate to provide speedy relief in the event of disaster of major proportions.
7. Endorsed the film "Breast—Self Palpation" as an excellent educational medium for use in the professional and lay women's groups.
8. Agreed to appoint 3 representatives of NATH and request Hawaii League of Nursing Education to appoint 3 representatives to serve on a committee to lay the ground work for a survey of nursing resources and educational facilities in the Territory and to assist as necessary with the survey to be made by the consultant, Division of Nursing Resources, Federal Security Agency; this same committee serving as representatives to follow through on any recommendations which the Holdover Committee of the Legislature may make on nursing education.
9. Approved the 1951 Budget presented by the Finance Committee.
10. Requested that individual letters of appreciation be sent to
  - a. American Nurses' Association for sending Miss Shirley Titus to participate in the Convention.
  - b. National Cancer Institute and the Hawaii Cancer Society for sharing Miss Rosalie Peterson with us.
  - c. The Committee on Program and Arrangements for its outstanding service and hard work.
  - d. To each District Association who contributed to the enjoyment of the Convention by sponsoring a special day.
  - e. To the Manager of the Mabel Smyth Building (Miss Eyman) for her fine cooperation.
  - f. To each exhibitor and to each participant in the program for their assistance.
  - g. To Mrs. Doris Caldwell, a friend of the Association who made the hundreds of dozens of cookies for us.
  - h. To the press for its splendid coverage of the Convention.

### ROVING REPORTER AT THE CONVENTION

The first day, Oahu Day, began in the usual style with registration and identification of delegates. Hostesses in muumuus greeted visitors as they arrived. Following the invocation by Reverend Judd, the business meeting got under way with Miss Harriet Kuwamoto, Vice President, NATH, presiding. The reports of officers and committee chairmen were good and the morning sped swiftly by. Many reports were mimeographed for more leisurely study by the members, certainly a swell idea when such a lot of material is being presented at one time.

Those who went to Waioli Tea Room for lunch came back looking very satisfied, but complained

of heavy eyelids during the afternoon. The afternoon session presented by the Hawaii League of Nursing Education, Mrs. Arlene Thompson, President, presiding, used the theme "The Nurse as Teacher." A skit entitled "Over the Back Fence" prologued a discussion period. The participants, Mrs. Kay Nichols as the obstetrical patient who found her hospitalization experience to be something like a coffee bean being ground through the mill, Miss Valerie Vayda as the patient who fortunately found interested, informative nurses during her stay in the hospital, and Miss Joyce Ma as the nurse who alleviated the fears as well as the pains of her patient, made a good introduction to the study groups and discussions that followed. In groups of 6 to 8, the audience pondered the two major questions on the role of the nurse as teacher. First, are nurses being adequately prepared for their role as teacher? Second, are there feelings or conditions of work which interfere with the nurse being a teacher? The general consensus brought out was that many nurses fail to fulfill their role as teacher because the training background had not stressed this phase nor had post-graduate staff education provided opportunities to alleviate this lack. Also, teaching is widely interpreted to mean formal instruction, whereas there are many occasions during which the nurse could do informal teaching while caring for patients. While the trend in nursing education in the better schools, at least, seems definitely to be emphasizing the role of the nurse as teacher, and progressive hospitals do offer good staff education programs, in which patient teaching is stressed, there is much to be done along these lines in making the nurse more useful in meeting the health needs of the community. This type of program that brings the audience out of itself is very stimulating and is certainly a good way to get "clams" to open up and indicate what they are thinking, and to tell something of their experience.

Following this the Hawaii League conducted its annual business meeting and realized that as a young organization, the year showed satisfying accomplishments through its participation in preparing the Cancer Workshop, securing Miss Benz of National League headquarters to survey local training and education programs and facilities, and Miss Shallit of USPHS to survey the local mental health program. An intensive membership drive will be conducted during the coming year. Newly elected officers: Miss Alison McBride, President; Miss Mary Cheek, Vice President; Miss Loreta Schuler, Treasurer; Sister Mary Albert, Director and Mrs. Rosie Kim Chang, Director.

The evening session Wednesday was highly ex-



citing and stimulating with Miss Shirley Titus, Executive Secretary of the California State Nurses Association as speaker. What a dynamic personality! How wonderful that she could be here to clarify our thinking and understanding of an economic security program for nurses! As Miss Titus pointed out, the heritage of nurses, dating back to the days when nursing was done by religious orders in the true spirit of self sacrifice, is one of which they can be justly proud, but in these days of twentieth century living, it is time to awaken to the fact that as human beings nurses have the same inalienable rights of all individuals in demanding improved living and working conditions. And, such improvements should in no way sacrifice the honor of the profession. Of course, the nurse must realize and accept her responsibility as a citizen as well as a nurse and work for the improvement of her entire community as well as her own.

Following this stirring address, the audience was invited to fire questions at the "Information Please Panel" which group included a hospital administrator, Miss Frances Alexander of Wahiawa General Hospital, a member of a Board of Directors, Mr. E. E. Black of Queen's Hospital, and a former patient, Mrs. Rebecca Clark. Discussion brought out the glaring fact that while the economic security program has many advantages it will mean increased costs to the public. Rich patients can take it, the poor patient will be given the necessary care, but what about us middlers? "That," said Miss Titus, "is a \$64.00 question!" However, other states have found a solution to this problem so there must be ways of accomplishing the objectives. Nurses of Hawaii must unite their efforts to achieve the goal of improving their own economic situations and providing improved nursing service for the community.

The social hour following was a scene of gaiety and color. Most of the nurses and their guests were garbed in colorful muumuus, holomuus and holokus. There were plenty of beautiful leis and corsages in evidence and the floral arrangements in the Alice Yates Salon were outstanding. As one moved from group to group there was continued discussion of the subject of the evening, and many present had the opportunity to take Miss Titus or members of the panel group aside to clarify further their own thoughts in this matter.

Thursday morning, with Mrs. Rosie Kim Chang presiding, was devoted to further discussion of the economic security program with Miss Titus to point out ways and means of accomplishing this program. First of all, the nurses must indicate their desire for such a program and their willing-

ness to cooperate. After that they must set up minimum standards. Such a program is a long-range affair and must be carefully planned and guided.

Forgive me, Maui! Meant to begin the Thursday session by telling how nicely the auditorium was decorated with a big pink flower map of Maui on its green panel and the large branches of pink plumeria near the stage. The incoming visitors were greeted by gracious hostesses in muumuus and given miniature paper maps of Maui with pink lei attached to pin on for the day. Now I can mention the lovely decorations for the luncheon at the Queen's Surf. The Nurses Association Office said that Maui Committees worked long and hard for this day of the program and that there is a great sheaf of correspondence to prove how thoroughly everything was planned. We thank you!



**MAUI DAY LUNCHEON AT QUEEN'S SURF**  
Left to right—front row: Isabelle Chung, Shirley Titus, Elizabeth Sheridan, Mary Dodd Giles. Back row: Rosalie Peterson, Mabelclaire Norman, Harriet Kuwamoto, Suzanne Bisset.

To show that nurses are aware of their role of citizen as well as nurse, just look at this program that was given on Thursday afternoon. "Panel Discussion—Constitution for the New State of Hawaii." And was it interesting! I wished that more John Q. Public could have been present to hear Mrs. Schattenburg, and Mrs. Emelia Centeio share honors with Mrs. Nancy Corbett, Constitutional Convention Delegate, Mr. Phillip Young and Mr. George Akita, University of Hawaii government students, in presenting such a clear picture of the constitution. A group of experts was on hand to clarify this material for the questioning audience. These distinguished gentlemen, Dr. Nils P. Larsen, Dr. Allen Saunders, University of Hawaii, Dr. Harold Roberts, University of Hawaii and Dr. Harold Loper, Department of Public In-



struction had also been Delegates. Incidentally, every nurse would do well to invest 25 cents in a copy of the constitution and "bone up" on its contents. Too bad if you missed this Thursday afternoon introduction to it!

Thursday evening the Student Nurses' Association held its second annual meeting at Mabel Smyth auditorium with about 200 in attendance. The outgoing officers gave reports and the new officers were introduced. This group is interested in establishing a scholarship fund that will make it possible for a representative to be sent to the ANA biennials.

Say, Miss Elizabeth Sheridan, Kula, Maui . . . you did make an excellent presiding officer Thursday afternoon.

Friday was Hawaii day and all comers received orchids from the Big Island. With Miss Margaret Nott presiding, a thoroughly educational program on breast cancer was presented. Dr. Lawrence Wiig gave the "Medical Aspects of Breast Cancer" and Miss Rosalie Peterson, Senior Nurse Officer, National Cancer Institute, "The Role of the Nurse in the Care of the Patient with Breast Cancer." The movie, "Breast—Self Palpation" was shown and following this a period of open discussion. The audience again participated actively.

Poi Luncheon at Queen's Hospital Nurses' Home, planned and given by Queen's Hospital Alumnae was entirely successful and truly delicious . . . that is, if you like Hawaiian food. Quite a number of people apparently do not.

Friday afternoon was given over to the meeting of the House of Delegates. Elsewhere you will find the results of the voting of this august body. It was an orderly and businesslike occasion and the agenda was covered by 4 p.m. New officers elected are: Miss Arlene Thompson, President; Mrs. Rosie Chang, Second Vice President; Miss Bernadette Yoshino, Treasurer; Mrs. Lois Bell, Oahu, Director; and Miss Thelma Hensley, Kauai, Director.

Your roving reporter was indeed impressed with the entire convention and regretted that more couldn't have been present. In case you're mildly curious about my credentials, I'll tell you who I am . . . Miss Jane Doe, R.N. See you next year!

#### APPRECIATION TO THE PROGRAM AND ARRANGEMENTS COMMITTEES

The planning and execution of a convention means lots of hard work for a few people and unless you have had the experience of serving on the committees that take charge of such affairs, you can't imagine just how much work this means. In many instances, the most indefatigable workers

are never mentioned when honors are making the rounds. We want to give honorable mention to one and all who were responsible for this year's stimulating get together, but in case you and you are missed, your efforts did not go unappreciated . . . at least not by any of us who have been in on the groundwork in the past.

Toshiko Ono as chairman of P and A Committee worked with Gerda Rutherford, Lillian Johnsrud, Frances Kupau, May Bowren and Jane Oki. Mrs. Norman and Mrs. McQueen, of course, got in on everything coming and going and spent many hours of overtime, as did the others, getting the innumerable pieces put together. Gladys Leong as chairman of a special committee to take care of floral decorations did a wonderful piece of work. She had assistants, but who these little beavers were remains a secret as we couldn't manage to have a word with Mrs. Leong before writing this up. This group gathered up the flowers, prepared the outstanding arrangements and in addition made most of the leis presented to our distinguished visitors and officers. Illa Storme was chairman of the committee for Oahu Day and at least one of her helpers was Mabel Gordon. May Bowren took care of the refreshments for Wednesday evening and were those home made cookies delicious! Suppose it's safe to say that Miss Eyman was helping out on this social event.

Now for our sister associations. Gloria Foster, Makawao, Maui was chairman of the committee for Maui Day and Miss Mary MacDonald of Hilo for Hawaii Day. Mrs. Dorothy Kaladic assisted Miss MacDonald. Mrs. I. Chung, Puunene, Maui, was in charge of flower arrangements for Maui Day; Mrs. M. Kamitaki and Miss E. Morishige, Wailuku, Maui were in charge of posters; Miss Eileen MacHenry and Miss Suzanne Bisset were in charge of the Maui Day luncheon at the Queen's Surf.

Sorry it wasn't possible to get every last name for you, Readers, but don't you agree that these committees did a wonderful job?

#### ANA NATIONWIDE STUDY

The nationwide study of nursing functions aims ultimately to give the public more economical and more effective nursing care. The research project, sponsored by ANA with the backing of all affiliated state and territorial nurses' associations is the most ambitious and far-reaching study of the nursing profession ever undertaken by any group. The research, estimated to cost nearly one million dollars, was authorized by the House of Delegates of the ANA at the Biennial Nursing Convention last May in San Francisco.

In order to utilize the nation's nursing personnel most economically and effectively, the study will seek to determine what should be the functions and relationships of nurses of all types—professional nurses, practical nurses and auxiliary workers. The findings are expected to set a pattern for determining accurately the staff requirements of hospitals of different sizes and types, and to guide schools of nursing in planning their curricula and in recruiting the necessary numbers of students with the proper preparation and background for nursing careers.

The first phases of the study will be limited to institutional nursing, but will probably be extended to other fields over the research period. The studies will be done in a sufficient number of various kinds and sizes of hospitals in all parts of the country, and under enough variations as to type and degree of illness, to accurately reflect differences in nursing functions. General and special hospitals, proprietary, voluntary and government hospitals will be included in the sample.

At intervals throughout the period of study, which it is estimated will take at least five years, state and district nurses' associations will carry on workshops and other activities to keep the nurse members fully informed on progress of the research.

#### A MESSAGE FROM THE NEW PRESIDENT

We are proud and honored that we are Professional Nurses. Our organization was formed years ago, by women who played a valiant part in opening the door to a larger world for us.

Our organization will be as successful as you and I make it. We have a wealth in our treasure house that has not been used. Many have a treasure buried and never utilized. Thus they do not know its real value. As we begin our work together for the coming year, may I ask the support of each professional nurse in the Territory of Hawaii.

We must move forward at a steady pace. We have much to accomplish, not only for ourselves, but for those who follow in our footsteps. This, however, must be carefully planned and cannot be completed in a few short months. The faith of our nurses today means security for our sisters of tomorrow.

For the coming year, may I suggest that we think together carefully on the following items:

1. That every nurse become a member of her professional organizations.
2. That we participate actively in community life and community organizations.
3. That we all work for Social Security for nurses.
4. That we participate as an organization in our local disaster program.

5. That we work together toward our Economic Security program.
6. That we support local legislation for public funds to be used in Nursing Education.

Are you as a nurse willing to accept this Challenge?

Your president,  
MRS. ARLENE THOMPSON

#### ABOUT SOCIAL SECURITY

Are you entitled to benefits under the Old-Age and Survivors' Insurance System? What must you do to receive benefits? How much will you pay?

The new amendments to Social Security Act signed by President Truman, August 28, provide greatly increased pensions to those now receiving them and those who will get them in the future. The full story will be carried by the *American Journal of Nursing* in the near future. Meantime, here are some highlights:

The majority of registered professional nurses will now be covered by the Act either on a compulsory basis or on a voluntary basis as follows:

a. *Self-employed professional nurses* on a compulsory basis if they earn a net annual income of \$400.00 a year;

b. *Nurse employees of non-profit institutions*, with the exception of members of religious orders, if (1) the employing organization or institution files a certificate that it desires extension of coverage to its employees, and (2) two-thirds of the employees concur in the filing of the certificate, and (3) their signatures are on a list accompanying the certificate. (Employees hired at a later date will also be included in coverage. Under provisions of the law, social security on this employer-employee elective basis will be available to: "Any charitable, or religious institution or any education, religious, scientific or literary organization, no part of whose earning go to the benefit of any private shareholder or individual.");

c. *Federal Government employees* not under any Federal retirement system;

d. *State and local government employees* under an agreement negotiated between the states and the Federal Security Administrator if they are not now covered by a retirement system.

*Tax rate on wages for employer and employee* will be 1½% on the first \$3,600.00 of annual income (the maximum wage credits allowed a worker for a calendar year) in 1950-1953; 2%, 1954-1959; 2½%, 1960-1964; 3%, 1965-1969; and 3¼%, 1970 and thereafter.

*Self-employed persons* will pay 1½ times the above rates. Private duty nurses with a net annual income of \$400.00 or more will be required to file an income tax return and pay the tax, which will be handled as an integral part of their income tax.

*To qualify, an individual must be "fully insured."* To be "fully insured" he must have a credit of (a) 40 quarters of coverage or (b) one quarter of coverage, acquired at any time, for each two quarters elapsing after 1950 up to, but excluding, the quarter in which he attains the age of 65 or dies. However, he will not be fully insured unless he has at least six quarters of coverage.



*Supplementary benefits* are provided for aged husbands, wives of insured persons, and dependent children under age of 18. *Survivors' benefits* are provided for widows, widowers, children and aged dependent parents of deceased employees. The amount of the lump sum death benefit has been increased.

### FROM YOUR LOCAL HEADQUARTERS

The annual convention has come and gone again and has left the office staff a little on the weary side but we here in this office all agree that it was worth it. I would like to say at this time that without the splendid cooperation of Mrs. McQueen many of the details which ran so smoothly would never have happened. Miss Helen Oyama, who is clerk for the Board for the Licensing, contributed greatly, too. My deepest thanks are very insufficient for a job so well accomplished. Thank you.

Miss Titus, who was sent to us by ANA, provided the highlights of the meetings and whether you agreed with everything she said or not, you will undoubtedly acknowledge that she spoke the truth and presented bare facts. The House of Delegates went on record as furthering an Economic Security Program for the nurses of this Territory and it shall be as you wish—with your help and only with your help.

One of the first things to be accomplished is increasing our membership. If we can have everyone working in and with our organization we can accomplish something. Are you willing to sit idly by and watch others reap in the benefits to be derived from such a program and not have them help even a little bit? What do you know about your organization? If you're proud of it—"sell" it to other nurses who are not members. What has the Association done for me? All right, what have you done for the Association? Your association has a Counseling and Placement Service for nurses; we are willing to assist you get the long-awaited Social Security; we are willing to assist you attain better working conditions and better salaries. Isn't that something the Association can and will do for nurses?

At the present time, we have approximately 1700 Registered Nurses who are actually in this Territory, yet only about 650 of them "Belong." This is approximately only 38 per cent of our potential membership.

If you were not fortunate enough to come to the convention, contact someone who was here, and find out more details of the plans for the coming year. How do they feel about an Economic Security Program? What can each nurse do? I have already mentioned increasing membership. Another thing you can do is to help your local organi-

zation by actively participating in its activities. There is much to be done this next year and there is plenty of stimulating work for all of us. Let's work together and make this a *big year* in the Association.

Take an active interest in community life as well. Are you all registered voters and are you voting? This is one of your privileges as an American Citizen but do you exercise it?

I am sure we all want to improve nurses and nursing and if we work together we can do it—begin now!

MABELCLAIRE NORMAN,  
*Executive Secretary*

### AN IN-SERVICE STAFF EDUCATION PROGRAM

Elsie K. Y. Ho, R. N.\*

For a few years now, the Nursing Education Department at Leahi Hospital has been responsible for the planning of an active in-service educational program for the personnel of the hospital. It began with an experimental program for the orientation of the new graduate nurse to tuberculosis nursing. Today, the department is called upon not only to orient the new nurse, but to teach various groups of workers on the hospital team. The over-all aims of the program are to provide the worker with opportunities to:

1. Learn about tuberculosis.
2. Learn about non-tuberculous conditions.
3. Get acquainted with community health and social agencies for the prevention of diseases and for the promotion of health.
4. Get acquainted with Hawaii's people and their cultural habits.
5. Get acquainted with Leahi Hospital as a center for the care of the tuberculous.

It is unfortunate that such a large number of our nurses are employed without having had previous instruction or experience in tuberculosis nursing. In a 1946 survey, we learned that only 24 percent of the schools of nursing in the United States offered any undergraduate clinical experience in tuberculosis at all.<sup>1</sup> For this reason, it is extremely difficult to find nurses trained in tuberculosis nursing. We have found that most of our nurses respond enthusiastically to such a thorough orientation program. It not only gives the nurse a chance to adjust to a new environment, but to many, it is an "eye-opener" into a new field of nursing.

\* (The Queen's School of Nursing; B. S. Western Reserve University, Cleveland, Ohio; Director of Tuberculosis Nursing Education, Leahi Hospital, Honolulu.)

<sup>1</sup> Public Health Reports 64:121 (Feb. 4) 1949.



The following outline has been organized for the *Orientation Program of a New Staff Nurse*. Most of this is given on duty-time and consists of individual and group teaching. Classroom and ward orientation cover these aspects:

1. Discussion of the organization and administration of Leahi Hospital.
2. Review of the general policies of the hospital.
  - a. Include material in "Orientation Book." (Contains general information about nurses' home rules, personnel policies and procedures.)
  - b. Show "ward routine" and "ward management" books.
3. Introduction to personnel.
4. Introduction to physical set-up of the hospital.
  - a. Conduct tour of hospital.
  - b. Discuss the general layout of a typical ward.
5. Classes.
  - a. On hospital routine:
    - (1) Take the nurse through a typical patient's day.
    - (2) Give instructions in regard to rest, diet, visitors, medical and surgical treatment of tuberculosis.
  - b. Aseptic technic and prevention of infection:
    - (1) Explain cough and tissue technic.
    - (2) Explain and demonstrate:
      - (a) Gown and mask technic.
      - (b) Temperature, pulse and respiration technic.
      - (c) Medication technic.
    - (3) Stress precautions to be taken in tuberculosis nursing.
  - c. Review admission, transfer, discharge procedures at Leahi Hospital.
  - d. Discuss nursing care in emergencies.
    - (1) The care of a patient with pulmonary hemorrhage.
    - (2) The care of a patient with spontaneous pneumothorax.
  - e. Discuss effective nursing care for the tuberculous. Stress:
    - (1) Having knowledge of the disease.
    - (2) Active participation in carrying out a good patient education program.
    - (3) Need for keeping informed on up-to-date practices; value of staff education program.
  - f. Encourage participation in Nurses' Association activities.
  - g. Lectures and discussions on tuberculosis as a communicable disease. (These are planned for the affiliating professional student nurses, but all graduates are encouraged to attend, if interested.)
    - (1) Etiology and bacteriology.
    - (2) Chemistry and pathology.
    - (3) Symptoms and diagnosis.
    - (4) Tuberculosis control.
    - (5) Collapse therapy principles and procedures.
    - (6) Medical treatment of tuberculosis.
    - (7) Surgical treatment of tuberculosis.
    - (8) Emotional aspects of tuberculosis.

- (9) Tuberculosis of the serous membranes.
- (10) Tuberculosis of the gastrointestinal tract.
- (11) Tuberculosis of the genitourinary tract.
- (12) Diet in tuberculosis.
- (13) Social service for the tuberculous.
- (14) Tuberculosis and associated conditions—pregnancy, asthma, diabetes, cardiac diseases.
- (15) Tuberculosis in children.
- (16) Epidemiology.
- (17) Rehabilitation for the tuberculous.
- (18) Special observation clinics.
  - (a) Medical staff conference.
  - (b) Outpatient clinic.
  - (c) Case finding clinic.

In addition to the above, weekly showing of educational films covering a wide variety of topics have taken place over long periods of time. These films have been borrowed from the following local sources:

Source:	Type of Film
1. Tripler General Hospital Medical, nursing, others	
2. Office of Health Education, Department of Health Tuberculosis, others	
3. Oahu Tuberculosis and Health Association	Mostly on tuberculosis
4. Hawaii Cancer Society	Cancer
5. Board of Underwriters of Hawaii, 320 Dillingham Building	Fire prevention
6. Mutual Telephone Company	Telephone courtesy
7. Squibb Company	Streptomycin in the treatment of tuberculosis; nutrition

All of the above film showings proved well worth while and assisted in keeping the staff nurse informed on a variety of subjects in medical and social sciences. We realize that this type of in-service educational program is costly to the hospital, but it is definitely a step toward the improvement of the quality of service to our patients and to the community.

HERE AND THERE

Children's Hospital:  
Recent newcomers to the nursing staff include **Miss Florence Ohye**, Queen's Hospital, Supervisor of Outpatient Department.  
**Miss Ruth Yamanaka**, Queen's Hospital, Night Supervisor.  
**Miss Wanda Alves**, Loma Linda Hospital, California, to surgery, replacing **Mrs. Katherine Taylor** who has returned to the mainland.  
**Miss Anna Gershiner**, Columbus Hospital, Chicago.  
**Miss Mieko Hiramoto**, Queen's Hospital.  
**Miss Myra Iida**, Paradise Valley School of Nursing, National City, California.

**Mrs. Jessie La Grange**, Highland-Alameda County Hospital, Oakland, California.

**Miss Kiyono Nagatani**, Queen's Hospital.

**Miss Ethel Nakamoto**, Loma Linda Hospital, California.

**Miss Kimie Toyama**, Queen's Hospital.

**Miss Sylvia Richards**, University of Minnesota.

**Mrs. Mary Yonamine**, St. Francis Hospital, has returned after a leave of absence.

**Miss Loreta Schuler**, Director of Nursing Service, Hawaii Chapter, American Red Cross, announced that 125 nurses on Oahu completed first aid courses in disaster nursing in October. Classes in first aid began at Kaneohe Hospital early in October with **Mrs. Ida Calvert Edwards** as instructor. Registration for another first aid course on Oahu began in November. **Miss Olga Larson**, School Nurse, Farrington High School, is Vice Chairman of the Red Cross Medical and Nursing Aid Subcommittee of the Disaster Preparedness and Relief Committee.

**Mrs. Flora Ozaki**, Public Health Nurse and Member of the Board for the Licensing of Nurses, left in September to attend Columbia University to take a course in Maternal and Child Health. We will miss her but wish her the best during this year.

Another Public Health Nurse is attending Columbia. **Miss Alvana Chang** has also enrolled and is working for a supervisor's Certificate in Public Health Nursing. Good luck, Alvana, and hurry back.

**Miss Leona Rubbelke** of South Dakota is the new Supervisor of Maternal and Child Health for the Department of Health here in Honolulu. Aloha, Miss Rubbelke.

**Miss Leona Adam**, formerly of Indiana, has come to the Islands to make her home. Miss Adam is a member of the American Nurses' Association Board of Directors. We welcome Miss Adam to our islands.

**Agnes** and **Sena Peterson** have decided not to return to the Islands. Sena is working occasionally in San Jose, California and Agnes has her headquarters in San Francisco. Agnes' address is: Bureau of Public Health Nursing, California State Department of Health, 760 Market Street, San Francisco.

When Miss Titus visited the Association at the Convention, she brought with her another distinguished guest—**Miss Mary Dodd Giles**. Miss Giles is co-author with Dr. Cabot on a textbook Surgical Nursing. Miss Giles is at present Director of Nursing and the school at Santa Rosa Junior College of Nursing. Aloha to Miss Giles. We enjoyed having her with us.

## NURSING SERVICE BUREAU

The Nursing Service Bureau and Physicians' Exchange are now on a 24 hour basis again beginning October 1. A man has been employed for the 11-7 a.m. shift and is working out quite well. You all know that this Nursing Service Bureau belongs to the nurses of the Territory and on request private duty nurses can be sent to any or all of the islands. The Physicians' Exchange is a service to the doctors of this community whereby they can always be reached. They have found it very valuable.

## CITY AND COUNTY OF HONOLULU

The officers of the City and County of Honolulu have had a rather difficult time in the last few months. **Myrna Campbell**, our worthy president, decided to go back to the University of Minnesota to work for her Master's Degree in Public Health. **Ruth Imai**, First Vice President, was transferred by the Department of Health to Kauai. So **Margaret Wong**, school nurse, in the role of Second Vice President is taking over and doing a very nice piece of work. Aloha to Myrna and Ruth—and the best of good wishes goes with them. We hope they will be back here soon. And congratulations to Margaret Wong for all her work.

**Mrs. Rae Keleher** resigned for maternity reasons and **Agnes Peterson** is not returning to the islands. She has accepted a position as Supervisor of Tuberculosis Nursing for the California State Department of Public Health. They have been replaced on the Board of Directors by **Miss Mary Cheek** and **Miss Laura Draper**.

A colorful Aloha Tea was given by the Leahi Staff and friends, on September 6, at the Leahi Nurses Cottage, in honor of **Miss Elsie Ho**, former Director of Nursing Education and her successor, **Miss Angela Carlucci**.

On September 9, **Miss Ho** departed for the mainland and is at present a graduate student at Columbia University, enrolled in an eighteen months program for a Master's Degree as Mental Hygiene Nurse Consultant.

**Miss Ho**, graduate of Queen's Hospital School of Nursing, Honolulu and Western Reserve University, Cleveland, Ohio, has been employed at Leahi for the past four years. She has been an active participant in several Nursing Groups and Community Agencies, and has contributed generously in promoting Nursing Education and Nursing Service in Honolulu.

**Miss Carlucci**, a graduate of Yale University, was at one time Clinical Instructor of Nurses at Queen's Hospital School of Nursing.

## NURSES' ASSOCIATION—COUNTY OF HAWAII

The Nurses Association, County of Hawaii held a rummage sale in August and raised \$232.70 which was used to pay the expenses of the delegates to the annual meeting of the Territorial Nurses' Association.

**Lenore Mori**, public health nurse in the Kohala district, became Mrs. Takumi Shirakawa on August 12.

**Ivy Oshiro** and **Harry Shiroma** were married August 20 in Honolulu. Mr. Shiroma teaches at Honokaa.

**Dorothy Murakami** was transferred to the Honolulu area of the Department of Health in August.

During the summer **Miss Cecelia MacDonald**, a teacher at the University of Washington, Seattle, visited her sister, **Mary Jean MacDonald**.

**Rose Hee** and **Sumiko Kumabe** attended the Cancer Workshop at the University of Hawaii in October.

**Dorothy Nagano**, former public health nurse and now physiotherapist with the Department of Health, was a recent visitor in Hilo.

**Nettie Hashida**, field nurse at Pepeekeo Sugar Company was married to **Herbert Morimoto** on September 9. Mr. Morimoto teaches in Hilo.

**Elizabeth Thurman**, anesthetist at Hilo Memorial Hospital, has moved to Crossville, Tennessee.

**Asayo Kimura**, graduate of St. Luke's Hospital, Chicago, is a new member of the Hilo Memorial Hospital nursing staff.

**Mrs. Peggy Wipperman** left for Texas in September to join her husband, Dr. R. P. Wipperman, who is stationed with the Army there.

**Ruth Sakai**, former public health nurse in Kohala has recently returned from the mainland where she spent the summer.

**Sally Nakano**, public health nurse in Honokaa is convalescing at Laupahoehoe Hospital following an automobile accident.

**Edna Baldwin** is now head nurse at Pepeekeo Hospital. The Nurses Association County of Hawaii sponsored a Cancer Institute held at the Hilo Memorial Hospital October 16 and 17. **Miss Sumiko Kumabe** was chairman.

**Mrs. Hatsumi Ishikawa** has enrolled for the University of Hawaii public health nursing course this fall. **Anita Knight** replaced her as school nurse at Hilo Intermediate School.

Official delegates who attended the Convention in Honolulu were: **Dorothy Kaladic**, chairman; **Eunice Graham**, **Sumiko Kumabe**, **Veda Warren**, **Utako Uchimura**, **Beatrice Wohlforth** and **Ruth Sakai**. Alternates, **Hatsumi Ishikawa**, **Violet Yamashiro**, **Elizabeth Stillman**, **Rose Hee**, **Margaret Barnett**, **Minnie Shelton** and **Kahiwa Lee**.

**Rose Hee**, President of the District, has been transferred by the Department of Health to the island of Kauai. **Annette Hammersland**, Vice President, will carry on until election time. We will miss Rose but wish her well in her new work.

**PROFESSIONAL LIABILITY INSURANCE  
NOW AVAILABLE TO ANA MEMBERS**

During September ANA announced that professional liability insurance, underwritten by the St. Paul-Mercury Indemnity Company, is now available to members. Details of the plans were sent to all members by letter and leaflet. Application may be made directly to the American Nurses' Association, 1790 Broadway, New York, N. Y.

**I DIDN'T KNOW**

By **LUCILLE SANDBERG\***

A telephone office,  
A store or two,  
The church, the school,  
A few houses, the "swimmin' hole"—  
The town was Richland, Washington.  
The year 1929.

I didn't know, then, that a "model" city  
Would rise upon this spot,  
I didn't know that uranium waste  
Would find its way to the river to rot  
And poison the stream.  
I didn't know . . .

There was no way of telling, then,  
That men from this stockpile  
Would fashion a flame to sear and blind—  
A flame so horrid and vile  
That all men cringed.  
I didn't know, I didn't know . . .

\*Public Health Nurse, Lanai City.

**MAHALO TO MISS BUCHANAN**

This is the last edition that our hardworking editor, Vi Buchanan, will edit. Miss Buchanan has been editor since 1946 and has worked long and hard and successfully at the job. At the time she took over, our BULLETIN joined the HAWAII MEDICAL JOURNAL and our part has grown and improved with every year. Miss Buchanan deserves all the credit for the excellent bulletins and the entire association regrets very much that she now seeks to "retire" from the job. Mahalo, Miss Buchanan, from the bottom of our hearts.

The new editor will be Miss Angela Carlucci, the new Educational Director at Leahi Hospital. Miss Buchanan hopes you will continue to assist the new editor and do even more to make the BULLETIN bigger and better.

**Young Bride:** I'm so upset, Doctor. I've just found that I've married a man that just can't bear children.

**Doctor:** Really you know, young lady, you can't expect everything.



**McARTHUR & SUMMERS**  
**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR • YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 • 7-8411



# BIRTCHE HYFREACATOR

Used by  
More Than  
**70,000**  
DOCTORS

... for the removal of skin growths, tonsil tags, cysts, small tumors, superfluous hair, and for other technics by electrodesiccation, fulguration, bi-active coagulation.

Now, completely redesigned the new HYFREACATOR provides more power and smoother control ... affording better cosmetic results and greater patient satisfaction. Doctors who have used this new unit say it provides for numerous new technics and is easier, quicker to use.

**\$4950 COMPLETE**

Send for descriptive brochure, "Symposium on Electrodesiccation and Bi-Active Coagulation" which explains the HYFREACATOR and how it works.

**THE BIRTCHE CORPORATION**  
5087 Huntington Drive Los Angeles 32, Calif.

## HYFREACATOR DEALERS

HOTEL IMPORT COMPANY  
Honolulu, T. H.

when an accident  
occurs . . . when  
crippling financial  
loss threatens . . .

**YOUR INSURANCE  
MUST PROTECT YOU  
THEN AND THERE!**

*There's no opportunity  
afterwards to revise . . .  
plug loopholes . . . increase  
coverage . . .*

*That's why a survey of  
your business and  
personal insurance  
programs is vitally  
important!*

**CONSULT**

**HOME INSURANCE CO. OF HAWAII, LTD.**  
HOMI INSURANCE BLDG. • 129 S. KING ST. • HONOLULU, HAWAII, U.S.A.

**KING ST., BETWEEN FORT AND BISHOP**

**NEW PHONE . . . 6-3521**

can  
we  
believe  
our  
census?



Yes, the fact is that a bacterial census following therapeutic doses of SULFASUXIDINE® succinylsulfathiazole will show a rapid reduction of *E. coli* organisms from 10,000,000 to less than 1,000 per gram of wet stool.

# Sulfasuxidine

succinylsulfathiazole



SULFASUXIDINE is specifically indicated as a safeguard against peritonitis before and after intestinal surgery, and is particularly valuable prophylactically in radical procedures.<sup>1</sup> It has also proved effective for control of ulcerative colitis and *E. coli* infections of the genitourinary tract,<sup>2</sup> and is considered a drug of choice in treatment of acute or chronic bacillary dysentery, including carrier states of this disease.<sup>3</sup> Toxic reactions are negligible, since 95% of the dose remains in the gastrointestinal tract.

Supplied in 0.5-Gm. tablets, bottles of 100, 500, and 1,000; powder in ¼ and 1 lb. bottles. Sharp & Dohme, Philadelphia 1, Pa.

1. Internat. Abstr. Surg. 83:1, July 1946.

2. Am. J. Obst. & Gynec. 49:114, Jan. 1945.

3. J.A.M.A. 128:1152, Aug. 18, 1945.

THEODORE H. DAVIES CO., HONOLULU • SOLE DISTRIBUTORS

# SIMPLE TEST PROVES INSTANTLY PHILIP MORRIS ARE LESS IRRITATING

*Now you can confirm for yourself,  
Doctor, the results of the  
published studies\**

## HERE IS ALL YOU DO:



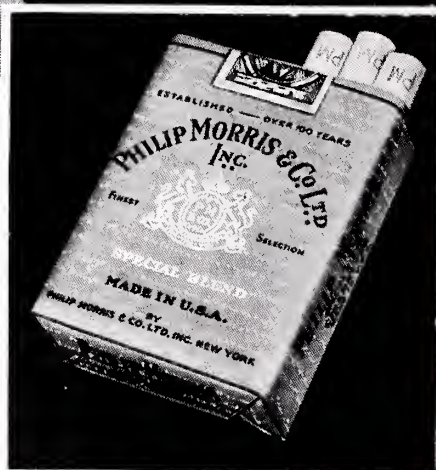
### 1 . . . light up a PHILIP MORRIS

Take a puff — DON'T INHALE. Just s-l-o-w-l-y let the smoke come through your nose. AND NOW

### 2 . . . light up your present brand

DON'T INHALE. Just take a puff and s-l-o-w-l-y let the smoke come through your nose. Notice that bite, that sting? Quite a difference from PHILIP MORRIS!

With proof so conclusive . . . with  
your own *personal experience* added  
to the published studies\* . . . would  
it not be good practice  
to suggest PHILIP MORRIS  
to your patients who smoke?



## PHILIP MORRIS

Philip Morris & Co., Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

\**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592; *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60



# AMERICAN EXPRESS CO. AGENCY

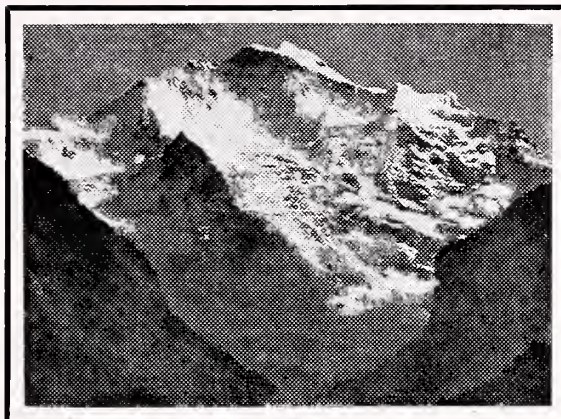
*Your 1951*

*Trip to*

# EUROPE

*can be*

**carefree and inexpensive**



*Die Jungfrau*

*Obtain Expert Advice and Planning at no extra cost*



## INTERNATIONAL *Travel Service*

In Honolulu: King at Bethel—phone 5-9517-6-7410  
In Waikiki: Outrigger Arcade—phone 9-3355-99-1514  
On Hawaii: Hilo Hotel Bldg., Hilo—phone 5328

*First Dr.'s Wife: My husband talks in his sleep, does yours?*

*Second Dr.'s Wife: No, he just chuckles, and it's damned annoying.*



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 - 7-8411



***complete line of . . .***

**A M E R I C A N  
F A C T O R S, L T D.**

**drug  
department**

**pharmaceuticals  
diagnostics  
prescription items  
drug supplies  
cosmetics**

**extensions: warehouse-236 and 319**

**manager: 238; order desk: 238 and 225**



# VISCOSITY

A vaginal jelly or cream with too heavy a viscosity is apt to remain in the posterior fornix and latently come in contact with the sperm. A lubricant with a very light viscosity tends to reduce required chemical barrier film. Koromex Jelly and Cream have the ideal viscosity determined by many years of laboratory tests and patient approval.

ACTIVE INGREDIENTS: BORIC ACID 2.0% OXYQUINOLIN BENZOATE 0.02% AND PHENYLMERCURIC ACETATE 0.02% IN SUITABLE JELLY OR CREAM BASES



## KOROMEX<sup>®</sup>

A CHOICE OF PHYSICIANS



HOLLAND-RANTOS COMPANY, INC. • 145 HUDSON ST., NEW YORK 13, N. Y.

MERLE L. YOUNGS, PRESIDENT



# Why so many Doctors Keep Babies on Carnation the Entire 1st year

1.

## *During Formula Days*

Carnation Evaporated Milk, with water and carbohydrates, is the safe and sure formula that can be adjusted to fit each baby's individual requirements.

2.

## *When baby goes off Formula*

Carnation diluted with an equal amount of water is nourishing whole milk in its most digestible form.

3.

## *From bottle to Cup Drinking*

Carnation's familiar flavor encourages baby's acceptance of cup-drinking... its uniformity discourages digestive upsets that may be caused by radical changes.

**Doctors agree** that radical changes in the care and feeding of a baby should be avoided—*especially* during the important first year of its life. That's why so many doctors advise mothers against taking baby off formula too soon...or changing to a different form of milk when formula days are over.

**For the constant** uniformity of Carnation Evaporated Milk... in butterfat, milk solid content, curd tension and viscosity... are positive factors in eliminating digestive upsets throughout baby's first year. And because

Carnation is not only pasteurized, but also sterilized *after* the can is sealed, it is doubly *safe* milk.

**Every can** of Carnation Milk comes from cows checked by Carnation's *own* inspectors...is tested in Carnation's *own* receiving stations...is processed under rigid control in Carnation's *own* evaporating plants. It's a brand you can recommend *by name*, as doctors have been doing for more than 50 years...with complete confidence that there is no better, safer milk for babies.

8 out of 10 mothers raising their babies on Carnation report that it was recommended by their doctor

*The Milk Every Doctor Knows*



"from  
Contented  
Cows"

# AUREOMYCIN

CRYSTALLINE

## in Primary Atypical Pneumonia

*The chemotherapy of primary atypical pneumonia has until recently been unsatisfactory. Aureomycin, which favorably influences the course even of severe cases, is now accepted as a treatment of choice in this disease.*



**Capsules:** Bottles of 25, 50 mg. each capsule.  
Bottles of 16, 250 mg. each capsule.

**Ophthalmic:** Vials of 25 mg. with dropper;  
solution prepared by adding 5 cc. of distilled  
water.

Aureomycin has also been found effective for the control of the following infections: acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, acute brucellosis, common infections of the uterus and adnexa, resistant gonorrhea, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-aerogenes group), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), tularemia and typhus.



# PROFESSIONAL MEN'S PROGRAM

AVAILABLE TO ELIGIBLE MEMBERS OF THE  
**MEDICAL • DENTAL • LEGAL Professions**

## INCOME PROTECTION WITH LIFETIME BENEFITS

The mental anguish resulting from loss of professional income because of ACCIDENT or SICKNESS can be banished under our Maximum Benefit Accident and Sickness . . .

**POLICY FORMS PG200N and UG200N**

### ACCIDENT BENEFITS

PAYS YOU FOR . . . Total disability, if incurred before age 60, per month FOR LIFE.....	\$400.00
Total disability, if incurred after age 60, per month FOR LIFE.....	\$200.00

### SICKNESS BENEFITS

PAYS YOU FOR . . . Total disability, if incurred before age 60, per month for 24 months..	\$400.00
PLUS—a monthly income thereafter FOR LIFE.....	\$200.00
Total disability, if incurred after age 60, per month for 24 months..	\$200.00
PLUS—a monthly income thereafter FOR LIFE.....	\$100.00

### ACCIDENTAL SPECIFIC LOSS BENEFITS

PAYS YOU FOR . . . Double Limb or Eye Loss.....	\$10,000.00
Single Limb or Eye Loss.....	3,000.00

### OTHER IMPORTANT FEATURES

- No house confinement required for either accident or sickness.
- No automatic termination age.
- Nonaggregate—Full limit of benefits paid for each period of disability.
- Waiver of premium provision.
- Incontestable clause.
- Arbitration clause.
- Full 24 hour coverage for both sickness and accident.
- No restrictive riders or limitations may be imposed on any policyowner after policies have been issued.
- Benefits are not reduced because of occupational change of duties.
- Accident benefits are effective from the first day.
- Commercial air travel passenger coverage.
- Pays partial accident disability benefits per month for 3 months—\$160.00.
- Licensed to operate in this state.
- Benefits are effective for sickness originating more than 30 days after the policy date.
- Sickness benefits are payable beginning with the eighth day of compensable disability.
- Covers tuberculosis and heart trouble originating more than six months after policy date. Covers all sickness except insanity or mental disorders.
- The Companies offer eligible members of your profession policies which guarantee your right to renew except for these reasons only: Nonpayment of premiums; if the insured retires or ceases to be actively engaged in the practice of the profession; or, if renewals are declined on all like policies issued to members of your profession in your state.
- This means that the Companies cannot decline to renew any individual policy without similarly declining to renew all like policies issued to members of your profession in your state.
- Plan is now in operation in this state.

**COULD YOU — AND YOUR FAMILY — LIVE WITHOUT INCOME?  
 PROTECT YOUR PROFESSIONAL INCOME—NOW**

MUTUAL BENEFIT HEALTH  
 & ACCIDENT Association—  
 HOME OFFICE: OMAHA,  
 NEBRASKA—Dr. C. C. Criss,  
 Chairman of the Board; V.  
 J. Skutt, President.



Philip C. Ciciarelli  
 Supt. of Agencies



John G. Ciciarelli  
 Resident Vice President

THE LARGEST EXCLUSIVE  
 HEALTH AND ACCIDENT  
 COMPANY IN THE WORLD.

HONOLULU OFFICES:  
 749-757 BISHOP ST.  
 Ground Floor  
 Dillingham Bldg.  
 TELEPHONE 5-6966







**S-M-A<sup>®</sup>**  
**builds**  
**husky**  
**babies**



**Ready-to-use S-M-A  
 is patterned after human milk**

... with respect to quantity and quality of essential nutritional factors. The nutritional history of S-M-A infants is similar to that of breast-fed infants.

S-M-A babies are well developed, with firm tissue; they are happy and contented.

The stools of S-M-A infants closely resemble those of breast-fed infants in color, odor, consistency and bacterial flora.

**Vitamin C Added**

S-M-A Concentrated Liquid—cans of 14.7 fl. oz.  
 S-M-A Powder—1 lb. cans



*Wyeth* Incorporated • Philadelphia 3, Pa.

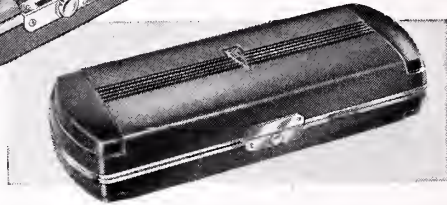




**new DURABILITY new CLEANLINESS**  
**new COMPACTNESS new BEAUTY**



**WELCH ALLYN**  
***sandura***  
**INSTRUMENT**  
**CASE**



This compact case is made of reinforced material to withstand far more stress and wear than any case will receive in normal use. It has amazing resistance to scratches and abrasion, and retains its like-new appearance for years.

The soft rubber lining protects the instrument against shock damage. Like the entire case, it can be washed with soap and water and sterilized by wiping with alcohol, an impossibility with old style plush-lined cases.

The "Sandura" case takes up less room in your bag and slips easily into your coat pocket.

All Welch Allyn otoscope sets or otoscope-ophthalmoscope sets with large handles are now available in this new "Sandura" case. Cases may also be purchased separately.

*Territorial Agents*

**HOTEL IMPORT COMPANY**

*Wholesale Druggists and Hospital Purveyors*

A Division of

VON HAMM-YOUNG COMPANY

Cooke and Kawaiahao Sts.



Honolulu

Phone 6-3561

"In addition to the relief of hot flashes and other undesirable symptoms (of the climacteric), a feeling of well-being or tonic effect was frequently noted" after administration of "Premarin."

Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being"

Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin'."

Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.



the clinicians' evidence

of the "plus" in

"PREMARIN"® therapy

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

*Estrogenic Substances (water-soluble)  
also known as Conjugated Estrogens (equine)*

Ayerst, McKenna & Harrison Limited  
22 East 40th Street, New York 16, N. Y.





## *An Observation on the Accuracy of Digitalis Doses*

*Withering* made this penetrating observation in his classic monograph on digitalis: "The more I saw of the great powers of this plant, the more it seemed necessary to bring the doses of it to the greatest possible accuracy."<sup>1</sup>

To achieve the greatest accuracy in dosage and at the same time to preserve the full activity of the leaf, the total cardioactive principles must be isolated from the plant in pure crystalline form so that doses can be based on the actual weight of the active constituents. This is, in fact, the method by which Digilanid® is made.

*Digilanid* contains all the *initial* glycosides from *Digitalis lanata* in crystalline form. It thus truly represents "the great powers of the plant" and brings "the doses of it to the greatest possible accuracy".

*Clinical investigation* has proved that Digilanid is "an effective cardioactive preparation, which has the advantages of purity, stability and accuracy as to dosage and therapeutic effect."<sup>2</sup>

*Average dose* for initiating treatment: 2 to 4 tablets of Digilanid daily until the desired therapeutic level is reached.

Average maintenance dose: 1 tablet daily.

Also available: Drops, Ampuls and Suppositories.

1. *Withering, W.*: An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.*: Digilanid and the Therapy of Congestive Heart Disease, *Am. J. M. Sc.* 209: 33-41 (Jan.) 1945.

Literature giving further details about Digilanid and Physician's Trial Supply are available on request.

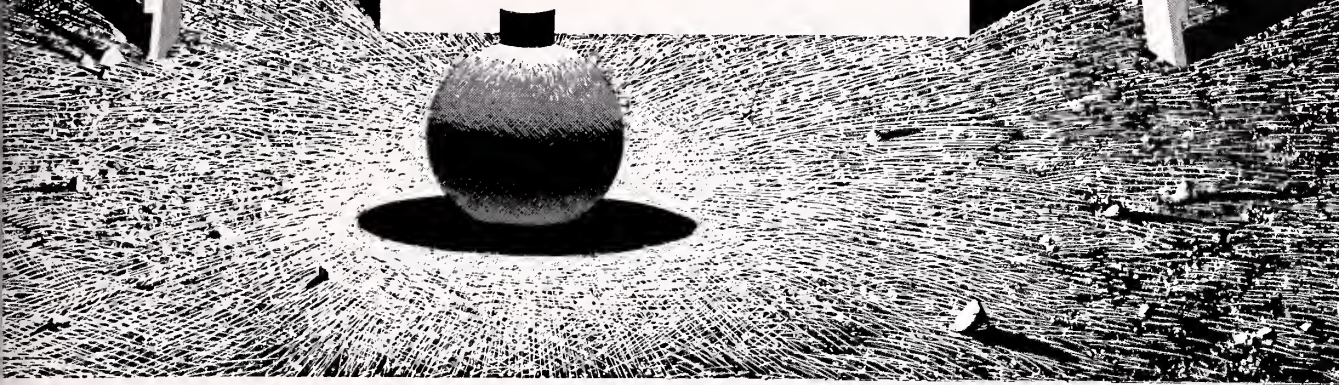
*Sandoz*  
*Pharmaceuticals*

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, NEW YORK

## INDEX TO ADVERTISERS

	PAGES		PAGES
Abbott Laboratories .....	88	Mead Johnson & Co.....	156
American Factors .....	144	Merck & Company, Inc.....	90
Ayerst, McKenna & Harrison, Ltd.....	153	Mutual Benefit .....	150
Birtcher Corporation .....	142	Parke, Davis & Company.....	82, 83
Borden Company .....	98	Pet Milk Company.....	132
Carnation .....	148	Pfizer & Co., Inc.....	92, 93
Dairymen's Association, Ltd.....	84	Philip Morris & Co., Ltd., Inc.....	144
Don Baxter, Inc.....	155	Sandoz Pharmaceuticals .....	154
Eli Lilly and Company.....	81, Insert	Schering Corporation .....	85
Holland Rantos Company, Inc.....	147	Schuman Carriage Co. Ltd.....	86
Home Insurance Co.....	142	Searle & Co.....	131
Hotel Hana-Maui .....	127	Sharp & Dohme.....	143
Hotel Import Co.....	152	Squibb & Sons.....	96
International Travel Service.....	145	Upjohn .....	91
Lederle Laboratories .....	149	Wander Company .....	89
Matson .....	94	Winthrop-Stearns, Inc. ....	95
McArthur & Summers.....	118, 124, 141, 145	Wyeth Incorporated .....	87, 151

THE REAL DANGER IN  
POTASSIUM  
DEFICIENCY  
IS LACK OF  
EARLY RECOGNITION

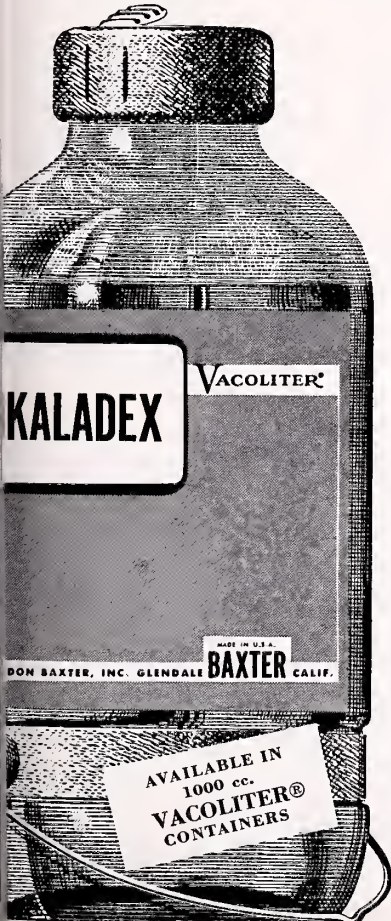


Know the causes . . . look for the symptoms and signs . . .  
treat promptly with

KALADEX

(Baxter 0.2% Potassium Chloride in 5% Dextrose Solution)

*Write for free abstract of the literature on  
potassium deficiency*



DON BAXTER, INC. • RESEARCH AND PRODUCTION LABORATORIES  
GLENDALE 1, CALIFORNIA

Principal Distributor: CROCKETT SALES COMPANY, P. O. Box 3017, Honolulu, T. H., Phone 6-8992





## “Truth never grows old” *Thomas Fuller, 1639*

With the passing years, ideas, theories and conceptions may change with new discoveries and growing knowledge.

But truth never grows old.

No matter how widely the pendulum may swing, *truth* remains the center of its path.

Because of its inherent soundness, Dextri-Maltose® is the carbohydrate of choice in more hospitals than ever before. It enjoys the confidence of ever-growing thousands of physicians.

And the physician who prescribes Dextri-Maltose in infant feeding follows a course confirmed by a great mass of evidence, for no other carbohydrate enjoys so rich and enduring a background of authoritative clinical experience.

However the pendulum may swing, facts remain facts, and truth never grows old.



**MEAD JOHNSON & CO.**  
EVANSVILLE 21, IND., U. S. A.



# HAWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

VOLUME 10

JANUARY-FEBRUARY, 1951

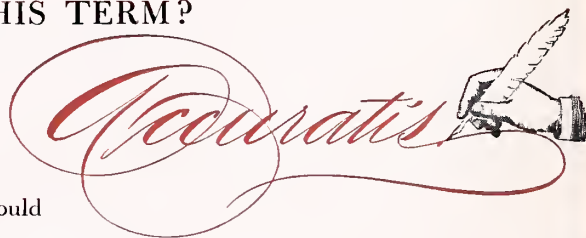
THE N.Y. ACADEMY  
OF MEDICINE  
FEB 17 1951  
LIBRARY

NUMBER 3



CARCINOMA OF THE STOMACH IN HAWAII J. E. Strode.....	173
THE MODERN PSYCHIATRIC HOSPITAL Daniel Blain .....	177
RHEUMATIC FEVER IN HAWAII Angie Connor and Tervuo Yoshina.....	181
SUBDURAL HEMATOMA Ralph B. Cloward.....	183
ALTERNATING BIDIRECTIONAL TACHYCARDIA Morton Berk and Henry Gotshalk.....	186
INTERNATIONAL CODE OF MEDICAL ETHICS.....	190
MANAGEMENT OF THE BURN PATIENT.....	191
FEATURES .....	192
INTER-ISLAND NURSES' BULLETIN.....	207

## REMEMBER THIS TERM?



Undoubtedly you would  
if you had practiced in 1876,  
when tintypes, buffalo robes, and elaborate mixtures  
of prescription ingredients were in vogue—and Eli Lilly and Company  
had just begun. Since then, the request to compound  
a prescription *accuratissime*, meaning *most carefully*,  
has become unnecessary. Today, progress has made pharmaceutical  
accuracy certain. So you don't whip out  
a quill pen and write *accuratis*.—when you specify Lilly.



*Lilly*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

*known  
and  
relied on  
the world over*



**ADRENALIN** (epinephrine, Parke-Davis) is today, as it has been for many years, one of the most versatile and useful drugs known and used the world over. Introduced to the medical profession by PARKE-DAVIS in 1901, ADRENALIN is widely used in many conditions — bronchial asthma, serum sickness, the Adams-Stokes syndrome, and anesthesia accidents.

**PARKE, DAVIS**

**SUPPLEMENT TO HAWAII MEDICAL JOURNAL**  
**JANUARY-FEBRUARY, 1951**

DOCTOR: For a constant reminder of medical meetings in the year  
1951, place this where you and your secretary can see it.

THE N.Y. ACADEMY  
OF MEDICINE

FEB 12 1951

LIBRARY. 1

### HOSPITALS

#### Children's

Monday—12:30 P.M.—weekly  
Luncheon—case reports  
Friday—12:30 P.M.—monthly staff luncheon and  
meeting—4th Friday

#### Kapiolani

Monday—4:00 P.M.—weekly  
Ob. and gyn. pathology seminar under Dr. C.  
Moran (open to all M.D.'s)  
Thursday—12:30 P.M.—monthly staff  
3rd Thursday

#### Kuakini

Friday—5:15 P.M.—monthly  
Dinner and staff meeting  
2nd Friday

#### Leahi

Friday—7:30 P.M.—Sinclair Club  
(For study of chest diseases)  
2nd Friday—monthly

#### Queen's

Thursday—12:30 P.M.—monthly  
Staff meeting and luncheon  
4th Thursday

#### St. Francis

Friday—12:30 P.M.—monthly  
Staff meeting and luncheon  
3rd Friday  
Pathology Conference (Dr. C. Moran)  
same time 2nd and 4th Friday

### TUMOR CLINICS

#### Kuakini Hospital—monthly

2nd Wednesday—1:00 P.M.

#### Queen's Hospital—bi-weekly

1st and 3rd Tuesday—1:00 P.M.

#### St. Francis Hospital—bi-weekly

2nd and 4th Tuesday—1:00 P.M.  
Call Dr. Walter Quisenberry, phone 7-1997, to  
schedule cases.  
For Home Nursing Cancer Service, call 5-2323  
or 5-2807.  
For Cancer Diagnostic Service, call any of the  
above numbers for details.

### SOCIETIES

#### Honolulu County Medical Society

Monthly meeting—1st Friday—7:30 P.M.  
Board of Governors—Tuesday of week preceding  
above—4:15 P.M.

#### Honolulu Academy of General Practice

2nd Monday—monthly—7:30 P.M.  
Pres.—Dr. A. L. Vasconcellos  
Vice Pres.—Dr. John M. Felix  
Sec.-Treas.—Dr. Robert F. Bailey

#### Hawaii Dermatological Society

Meets at announced dates  
Pres.—Dr. Harold M. Johnson  
Sec.-Treas.—Dr. Harry L. Arnold, Jr.

#### Honolulu Eye, Ear, Nose & Throat Society

3rd Thursday—monthly  
Pres.—Dr. O. D. Pinkerton  
Sec.-Treas.—Dr. John Frazer

#### Honolulu Obstetrical & Gynecological Society

3rd Monday—monthly—7:30 P.M.  
Pres.—Dr. Lyle Bachman  
Sec.-Treas.—Dr. Rodney West

#### Honolulu Pediatrics Society

3rd Thursday—monthly (closed)  
Pres.—Dr. Walter B. Herter  
Sec.-Treas.—Dr. Teruo Yoshina

#### Honolulu Surgical Society

3rd Friday—alternate months (Jan., Mar., May,  
etc.)—7:30 P.M.  
Pres.—Dr. Laurence M. Wiig  
Sec.-Treas.—Dr. Lester Yee

#### Hawaii Territorial Medical Association

May 3 to 6, 1951  
Meets in Honolulu

#### Territorial Ass'n of Plantation Physicians

Meets November 7-19, 1951 (jointly with below)  
Pres.—Dr. Frank Hatlelid, Waialua  
Sec.-Treas.—Dr. P. H. Liljestrang, Aiea

#### Pan-Pacific Surgical Congress

Meets in Honolulu every 3rd year. Next meeting,  
November 7-19, 1951.  
Pres.—Dr. F. J. Pinkerton, Honolulu  
Sec.—Dr. F. J. Halford, Honolulu

*Compliments of*



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR • YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 • 7-8411





# ADRENALIN<sup>®</sup>

Circulatory stimulant, vasoconstrictor, resuscitant, and hemostatic, this pure crystalline hormone is one of the truly basic drugs — an invaluable aid in office, in hospital, and in clinic. It is an important adjunct in local anesthesia, valuable in arresting superficial hemorrhage, and a standby for decongestion of engorged mucous membranes.

**ADRENALIN** is available as ADRENALIN CHLORIDE SOLUTION 1:1000, ADRENALIN CHLORIDE SOLUTION 1:100, ADRENALIN IN OIL 1:500 and in a variety of forms to meet all medical and surgical requirements.

COMPANY







NOW PROOF... in an instant, Doctor,  
PHILIP MORRIS are LESS IRRITATING

*Just Make This Simple Test:*



**1** ... light up a  
PHILIP MORRIS  
Take a puff—DON'T INHALE. Just  
s-l-o-w-l-y let the smoke come through  
your nose. Easy, isn't it? AND NOW...

**2** ... light up your present brand  
DON'T INHALE. Just take a puff and  
s-l-o-w-l-y let the smoke come through  
your nose. Notice that bite, that sting?  
Quite a difference from PHILIP MORRIS!

YES, your own *personal experience* confirms the results of the clinical  
and laboratory tests.\* With proof so conclusive, would it not be good practice to  
suggest PHILIP MORRIS to your patients who smoke?

**PHILIP MORRIS**

Philip Morris & Co., Ltd., Inc.  
100 Park Avenue, New York 17, N. Y.

\**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;  
*Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

*a critical evaluation  
of drugs for treating  
urinary tract  
infections*

it has been noted that:



**SULAMYD®**

(Sulfacetimide)

"combines the features of good antibacterial activity, low toxicity, and rapid renal elimination resulting in high urinary level. . . Sulfacetimide . . . has the advantage of high solubility even in the physiological acid range of the urine, thereby minimizing almost to a negligible point the danger of concrement formation. . . ."<sup>1</sup> Because of its wide antibacterial range it may be preferable to penicillin and streptomycin.<sup>2</sup> It is well tolerated and remarkably free from side effects.<sup>3</sup>

**DOSAGE:** Therapeutic: 2 tablets t.i.d. for 10 days.  
Prophylactic: 1 tablet t.i.d.

**SULAMYD** Tablets 0.5 Gm. in bottles of  
100 and 1000 tablets.

1. Nesbit, R. M., and Clickman, S. I.: J. Michigan State M. Soc. 46:664, 1947.

2. Dodson, A. I.: West Virginia M.J. 45:1, 1949.

3. Seneca, H.; Henderson, E., and Harvey, M.: J. Urol. 67:1105, 1949.

*Schering*

CORPORATION • BLOOMFIELD, NEW JERSEY



**SULAMYD**

"In addition to the relief of hot flashes and other undesirable symptoms (of the climacteric), a feeling of well-being or tonic effect was frequently noted" after administration of "Premarin."

Harding, F. E.: *West. J. Surg. Obst. & Gynec.* 52:31 (Jan.) 1944

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: *Am. J. Obst. & Gynec.* 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being."

Glass, S. J., and Rosenblum, G.: *J. Clin. Endocrinol.* 3:95 (Feb.) 1943

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Perloff, W. H.: *Am. J. Obst. & Gynec.* 58:684 (Oct.) 1949.



the clinicians' evidence

of the "plus" in

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

"Premarin" contains estrone sulfate plus the sulfates of equilin, equilin,  $\beta$ -estradiol, and  $\beta$ -dihydroequilin. Other  $\alpha$ - and  $\beta$ -estrogenic "diols" are also present in varying amounts as water-soluble conjugates.

**"PREMARIN"®**  
therapy

*Estrogenic Substances (water-soluble)  
also known as Conjugated Estrogens (equine)*

Ayerst, McKenna & Harrison Limited  
22 East 40th Street, New York 16, N. Y.





can  
we  
believe  
our  
census?



Yes, the fact is that a bacterial census following therapeutic doses of SULFASUXIDINE® succinylsulfathiazole will show a rapid reduction of *E. coli* organisms from 10,000,000 to less than 1,000 per gram of wet stool.

# Sulfasuxidine

succinylsulfathiazole



SULFASUXIDINE is specifically indicated as a safeguard against peritonitis before and after intestinal surgery, and is particularly valuable prophylactically in radical procedures.<sup>1</sup> It has also proved effective for control of ulcerative colitis and *E. coli* infections of the genitourinary tract,<sup>2</sup> and is considered a drug of choice in treatment of acute or chronic bacillary dysentery, including carrier states of this disease.<sup>3</sup> Toxic reactions are negligible, since 95% of the dose remains in the gastrointestinal tract. Supplied in 0.5-Gm. tablets, bottles of 100, 500, and 1,000; powder in ¼ and 1 lb. bottles. Sharp & Dohme, Philadelphia 1, Pa.

1. Internat. Abstr. Surg. 83:1, July 1946.
2. Am. J. Obst. & Gynec. 49:114, Jan. 1945.
3. J.A.M.A. 128:1152, Aug. 18, 1945.

THEO. H. DAVIES CO., HONOLULU

• SOLE DISTRIBUTORS



# Cortone<sup>®</sup>

## NOW AVAILABLE IN TABLETS FOR ORAL USE

*As well as in Saline Suspension  
for Parenteral Therapy*



CORTONE\* (Cortisone) now is available in tablets for oral administration, as well as in saline suspension for parenteral use, through your usual sources of medicinal supplies.

Clinical studies have demonstrated that the therapeutic activity of Cortone administered orally is comparable to that of the parenteral form. Dosage requirements are approximately the same, and the two routes of administration may be used interchangeably or additively at any time during treatment.

CORTONE Tablets, 25 mg. each, are supplied in bottles of 40, totaling 1 gram, the equivalent in Cortone content to 2 vials of the saline suspension. The cost per gram to the physician is approximately the same as that of the saline suspension for parenteral use.

*Literature on Request*

*Key to a New Era in Medical Science*

# Cortone<sup>®</sup>

ACETATE

(CORTISONE Acetate Merck)

(11-Dehydro-17-hydroxycorticosterone-21-acetate)



**MERCK & CO., INC.**

*Manufacturing Chemists*

RAHWAY, NEW JERSEY

\*CORTONE is the registered  
trade-mark of Merck & Co., Inc.  
for its brand of cortisone.

# REGARDLESS OF INDICATED THERAPY

## *Nutrition is a Primary Factor*



Whether the condition under treatment is an acute infection, a bowel upset, an injury or a metabolic derangement, nutrition is always a primary factor in therapy. Regardless of other indicated measures, nutritional adequacy is essential for prompt recovery.

When dietary supplementation is the indicated means of increasing the nutrient intake, the food drink, Ovaltine in milk, can prove highly beneficial. Pro-

viding significant amounts of all nutrients considered essential, it virtually assures dietary adequacy when the recommended three glassfuls daily are taken in conjunction with even a fair diet.

Temptingly delicious and readily digested, this dietary supplement fits well into the framework of most indicated diets, and finds ready patient acceptance. Its generous nutrient content is detailed in the table below.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

### *Ovaltine*

Three servings of Ovaltine, each made of  
1/2 oz. of Ovaltine and 8 oz. of whole milk,\* provide:

PROTEIN . . . . .	32 Gm.	VITAMIN A . . . . .	.3000 I.U.
FAT . . . . .	32 Gm.	VITAMIN B <sub>1</sub> . . . . .	1.16 mg.
CARBOHYDRATE . . . . .	65 Gm.	RIBOFLAVIN . . . . .	2.0 mg.
CALCIUM . . . . .	1.12 Gm.	NIACIN . . . . .	6.8 mg.
PHOSPHORUS . . . . .	.094 Gm.	VITAMIN C . . . . .	30.0 mg.
IRON . . . . .	12 mg.	VITAMIN D . . . . .	417 I.U.
COPPER . . . . .	0.5 mg.	CALORIES . . . . .	.676

\*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.







## *Milestone in a Career!*

We see it happen over and over again—and it's one of the greatest satisfactions we enjoy in this happy business of selling Cadillac cars.

It's when a man comes into possession of his first Cadillac—and we see the wonderful things it does for him.

We see his happiness as he places his order—not as the result of a sudden inspiration, but because he has gradually reached the conclusion that he has earned the right to enjoy the unquestioned best.

And then we see him on that happy day when his car is available for delivery—and he settles himself so proudly behind the wheel.

He's a little quizzical, we sometimes note. Could it be,

he wonders, that he has been anticipating a bit too much?

And then he's out in the street—headed for home the *long way 'round*.

Those are thrilling days that follow.

There's the first long ride with the family . . . the first trip to the office . . . and the time he learns, in an emergency, that his car is worth its *whole price* in safety alone.

And then, almost before he knows it, the odometer registers a thousand miles—and he's back to tell us all about it. And, perhaps, to grumble a little bit at giving it up—even for a little while!

Yes, it's a priceless privilege to watch all this. Makes a man feel that he's doing good.



**SCHUMAN CARRIAGE COMPANY**

Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU



**release  
the**

# FLOOD GATES

## *in Cardiac Edema Control*

"... the diuretic drugs not only promote fluid loss but in many instances also effectively relieve dyspnea . . . not only may the load on the heart be decreased but there may also occur an increase in the organ's ability to carry its load . . .

With good average response the patient perhaps voids about 2000 cc. of urine daily, but in exceptional instances the amount rises to as high as 8000 cc."<sup>1</sup>

"Not only are the diuretics of immense value in cases of left ventricular failure . . . but where edema is marked, as it is most likely to be in failures occurring in individuals with chronic nonvalvular disease with or without hypertension and arrhythmia, their employment is often productive of an excellent response. In [edematous patients with] active rheumatic carditis (rheumatic fever) the use of these drugs may be life-saving."<sup>2</sup>

Salyrgan-Theophylline is effective by muscle, vein or mouth.

# **salyrgan-<sup>®</sup>** **THEOPHYLLINE**

BRAND OF MERSALYL AND THEOPHYLLINE  
**TIME TESTED • WELL TOLERATED**

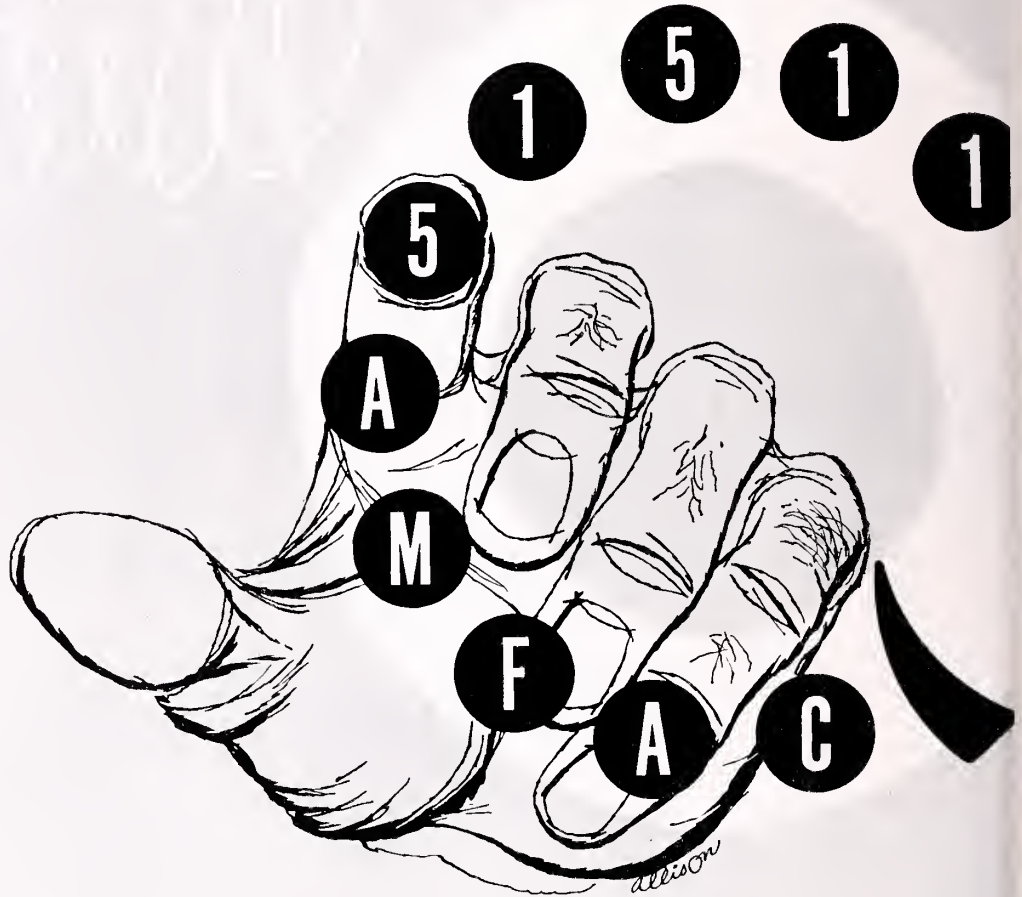
*Winthrop-Stearns* INC.  
NEW YORK, N. Y. WINDSOR, ONT.

AMPULS (1cc. and 2cc.) • AMPINS (1cc.) • TABLETS

1. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 5th ed., 1946, 704-705.

2. Beckman, H.: Treatment in General Practice. Philadelphia, Saunders, 6th ed., 1948, 744.

Salyrgan, trademark reg. U. S. & Canada—Ampins, reg. trademark of Strang Cabb & Co., Inc.



***complete line of . . .***

**A M E R I C A N  
F A C T O R S , L T D .**

**drug  
department**

pharmaceuticals  
diagnostics  
prescription items  
drug supplies  
cosmetics

extensions: warehouse-236 and 319

manager: 238; order desk: 238 and 225





NO FORTIFICATION NEEDED

The vitamin content of S-M-A is well in excess of the requirements of the normal infant, and is more constant than the vitamin content of breast milk.

*A Complete, Protective Infant Food . . .*

S-M-A, diluted and ready to feed, provides in each quart the following proportions of the minimum daily requirements for infants.

VITAMIN A 5,000 U.S.P. units	333%
VITAMIN D 800 U.S.P. units	200%
THIAMINE 0.67 mg.	250%
RIBOFLAVIN 1 mg.	200%
VITAMIN C 50 mg.	500%
NIACINAMIDE 5 mg.	—

Ready-to-feed S-M-A is the most complete formula for infants. Its protective vitamins are administered in the most satisfactory way—right in the food and in each feeding. No danger of forgetting, no extra burden for busy mothers.

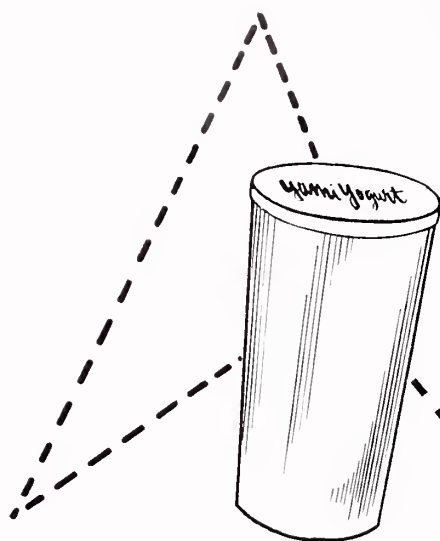
No infant food is more like breast milk than S-M-A—in content of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physical properties.

S-M-A CONCENTRATED LIQUID—cans of 13 fl. oz.  
S-M-A POWDER—1 lb. cans



**S-M-A<sup>®</sup>**  
*vitamin C added*  
*builds husky babies*

Wyeth Incorporated, Philadelphia 3, Pa.



**Pure  
Bulgarian-Cultured**

*yami yogurt*

Trade Mark Reg. U.S. Pat. Off.

**Now Available In Hawaii**

*Ready to use, right from the jar.  
Good to eat as it is, or use it  
like cream or cottage cheese;  
as salad dressing, on pineapple,  
strawberries, high-acid fruits.*

*Available under refrigeration  
at food stores — or  
telephone Dairymen's for  
home delivery.*

This lactic-acid-cultured milk food is an important aid to digestion and health at every stage of life—from infant feeding to the time of clinical problems of senescence.

The Bulgarian cultures used in Yami Yogurt are propagated under strict laboratory control at the Rosell Bacteriological Dairy Institute at the Trappist Monastery in La Trappe, Quebec, Canada.

The final introduction into sterilized milk and incubation at 110 deg. F. acts upon the lactose of the milk and produces an unusually large amount of lactic acid (1% to 3%). This final step is performed under strict laboratory conditions at Dairymen's in Hawaii.

*Produced  
and Distributed  
Exclusively*

**by**

***Dairymen's* ASSOCIATION, LTD.**

A Division of Creameries of America, Inc.

# HAWAII MEDICAL JOURNAL

## and INTER-ISLAND NURSES' BULLETIN

Volume 10  
Number 3

JANUARY-FEBRUARY, 1951

\$2.00 per Year  
35c per Copy

Published Bi-Monthly by

THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

### THE HAWAII TERRITORIAL MEDICAL ASSOCIATION 1950-1951

#### OFFICERS

R. L. HILL, Honolulu.....	President
HARRY L. ARNOLD, JR., Honolulu.....	President-Elect
LEO BERNSTEIN, Hilo.....	Vice-President from Hawaii County
S. L. YEE, Honolulu.....	Vice-President from Honolulu County
WILLIAM GOODHUE, Eleele.....	Vice-President from Kauai County
R. F. COLE, Paia.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

#### COMMITTEE CHAIRMEN

GROVER A. BATTEN.....	{ Cancer Committee Resolutions Committee
SAMUEL D. ALLISON.....	Health Education Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	HAWAII MEDICAL JOURNAL
WILLIAM H. STEVENS.....	Committee on Psychiatry and Neurology
SAMUEL L. YEE.....	By-Laws Committee
THOMAS H. RICHERT.....	Advisory Board for Woman's Auxiliary
RICHARD C. DURANT.....	Public Service Committee
HARRY L. ARNOLD, JR.....	Committee on Public Policy and Legislation
LAURENCE M. WIIG.....	Scientific Works Committee
VERNE C. WAITE.....	Postgraduate Committee
ROBERT D. MILLARD.....	Fee Schedule Committee

#### OFFICERS—COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....L. Bernstein, Hilo	S. L. Yee	W. Goodhue, Eleele	R. F. Cole, Paia
<i>Vice-President</i> .....T. D. Woo, Pepekeo	J. W. Devereux	K. K. Fujii, Kapaa	E. Kushi, Wailuku
<i>Secretary</i> .....P. Okumoto, Hilo	W. Walsh	K. Kuhlman, Koloa	E. T. Shimokawa, Lahaina
<i>Treasurer</i> .....M. L. Chang, Hilo	W. Ito	K. Kuhlman, Koloa	E. T. Shimokawa, Lahaina

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1951, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second-class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.





... with a Solid Foundation

For the infant, a sound future depends largely on the kind of nourishment given in the first few all-important months of life.

These are the months when the demand for protein is greatest. And that's one good reason why DRYCO is often recommended when necessary to supplement or replace breast feeding.

It is the 2.7 to 1 ratio of protein to fat in DRYCO formulas that gives this trusted milk such an outstanding advantage, for

it most nearly approximates the balanced *nourishment* and *digestibility* of milk from the human breast.

#### Solid Nourishment—Vitamin Fortified

Always the best fresh milk, modified to provide a ratio of 2.7 to 1 of protein to fat, easily digested, moderate carbohydrate content permitting flexibility, vitamin enriched—and specially packed to retain its original freshness in any climate—that's DRYCO!

Write for detailed information to:

**THE BORDEN COMPANY, Export Division**  
350 Madison Avenue, New York 17, N. Y., U. S. A.

# DRYCO

VITAMIN FORTIFIED



# Observations on Carcinoma of the Stomach in Hawaii

## A Study of 140 Consecutive Cases Coming to Surgery

J. E. STRODE, M.D.

HONOLULU

IN SPITE of earlier detection, more accurate diagnosis and better surgical treatment, carcinoma of the stomach continues to be so difficult to cure or long alleviate that some of our medical colleagues in Hawaii seriously doubt the advisability of surgical intervention in this condition. This study of the subject was made in order to determine as accurately as possible what I had been able to accomplish by surgery in the past and what, if anything, had been learned from this experience that might improve our methods of approach to the problem in the future. Admittedly, the number of cases studied is small in comparison with many other reported series, and the end result in the cases yet living remains to be determined. Nevertheless, it is believed that the study has some merit because it represents the experience of one individual and because, due to the limited geographical distribution of our archipelago, it has been possible to obtain 100 per cent follow-ups to January 1, 1950, on all the 140 consecutive cases studied.

In reviewing statistical data regarding treatment of cancer of the stomach, one is impressed by the varying results reported. Since end results in any considerable number of cases will depend upon early recognition and early adequate surgical removal of the lesion, it would seem that the discrepancy in results from clinics doing good gastric surgery is dependent to a considerable measure at least on what the pathologist determines is malignant in borderline cases.

All the cases included in this study were without doubt carcinomas and unfortunately, clinically, there was little if any doubt in most cases as to what exploration would reveal. Carcinoma in situ found in ulcer craters and in questionable early malignant changes occurring in various types of gastritis, or the doubtful malignant changes associated with papillomas of the stomach, present pathological problems about which there is much disagreement and, therefore, such cases are not included in this report.

I have had occasion to operate upon approximately 250 cases of carcinoma of the stomach but in only the last 140 consecutive cases could sufficient data be obtained to justify inclusion in this study. These patients were operated upon during the period from January 1, 1936 to January 1, 1950. There were 68

cases operated upon prior to January 1, 1945 that could be followed for at least five years. Thirty-seven cases, or 54 per cent, were subjected to radical resection. Five died from the surgery that was done, leaving 32 cases for study. Eight, or 25 per cent, lived five years or longer. One case lived eight years; one five years nine months; the remaining six are still living and clinically free of recurrence at five years, six years two months, seven years, seven years ten months, and seven years eleven months, respectively (Table 1). Two of these cases were Caucasian, one was Portuguese-Hawaiian and the other 5 were Japanese. Of the 8 cases surviving resection for five years or longer, 2 were of the linitis plastica type of malignancy, and in none could metastatic lymph node involvement be demonstrated.



DR. STRODE

TABLE 1.—*Summary of outcome in 140 consecutive cases of infiltrative adenocarcinoma of the stomach.*

140 cases operated upon.
68 cases 5 years or more follow up.
37 cases (54%)—Radical surgery, 5 died of operation.
32 cases survived operation.
8 cases (25%)—Lived 5 years or longer.
One case lived 8 years.
One case lived 5 years, 9 months.
6 cases living and clinically free of recurrence at
5 years, 10 months
6 years
6 years, 2 months
7 years
7 years, 10 months
7 years, 11 months

It is our belief that the degree of malignancy of gastric carcinoma as determined by microscopic study may be difficult to determine and frequently



varies with the opinion of the individual pathologist. Of more prognostic significance is the freedom of involvement of regional lymph nodes.

Of the 140 cases operated upon, 84, or 60 per cent, were subjected to radical operation; in 56 cases, or 40 per cent, the lesion was considered irremovable. Gastroenterostomy was done in 11 cases and gastrostomy in 5. It is generally agreed that such palliative procedures are rarely of much value. All the cases in which radical operation was not done are now dead and the average length of life of those surviving the immediate operation was 4.2 months (Table 2).

TABLE 2.—Comparison of results in operable and inoperable cases.

140 cases operated upon.
84 cases (60%)—Radical operation.
56 cases (40%)—Lesion irremovable.
11 cases had gastro-enterostomy.
5 cases had gastrostomy.
All inoperable cases now dead.
Average length of life of those surviving operation
4.2 months.

Of 19 total gastrectomies, 10 died from metastasis, the average length of life after operation being nine and one-half months. One patient lived two years and seven months. Seven patients are still living, the longest time from date of operation being thirteen months. Of the entire group of 140 cases operated upon, 20 are now living, which represents 27.2 per cent of the cases surviving radical operation and 14.3 per cent of the whole series. The immediate operative mortality of the 140 cases subjected to surgery was 11.4 per cent. The surgical mortality for the 84 radical operations was 12 per cent, and this included the 19 total gastrectomies with 2 deaths or 10.5 per cent (Table 3). All deaths in the series resulted either from the immediate effects of the operation or from the disease for which they were operated upon, except three. One died eight weeks postoperatively of a cerebral hemorrhage; one two months postoperatively from intestinal obstruction; and one nine months postoperatively following craniotomy for removal of a spongioblastoma.

TABLE 3.—Surgical mortality of gastrectomy for carcinoma.

140 operations—16 deaths—11.4%.
84 radical operations—10 deaths—12%.
19 total gastrectomies—2 deaths—10.5%.

In speaking of radical operations for carcinoma of the stomach, we mean either a radical resection or total gastrectomy. In radical resection, the stomach is removed well proximal to the lesion, together with a portion of the duodenum. The omentum is removed, and as much of the gastrohepatic ligament as preservation of the hepatic artery and celiac axis permits. We are particu-



FIG. 1.—Radical resection of the stomach for carcinoma, including the omentum, gastrohepatic mesentery and lymph node bearing area along the terminal esophagus and lesser curvature.

larly careful to remove the lymph node bearing area along the terminal esophagus and lesser curvature of the stomach (Fig. 1). The peritoneum overlying the pancreas and forming the posterior wall of the lesser omental sac is removed as thoroughly as technically possible (Fig. 2 A&B). The left gastric artery is routinely severed near its origin and the coronary vein near

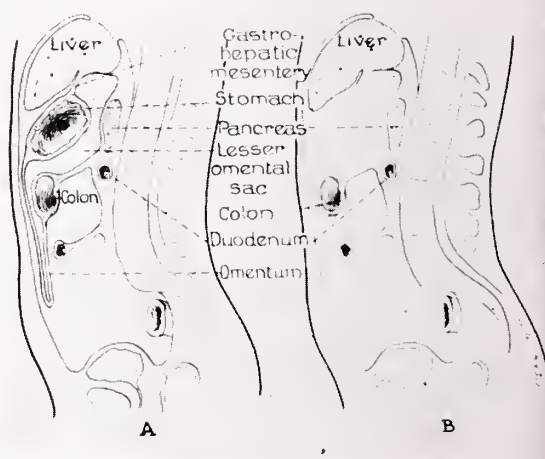


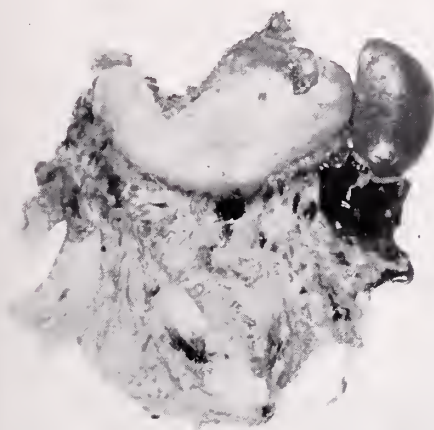
FIG. 2.—A. Diagrammatic anatomical drawing to show the reflections of the peritoneum about the stomach. B. Showing structures remaining after radical gastric resection.



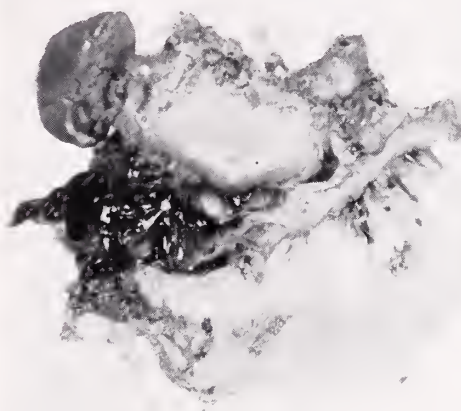
its termination in the portal vein. In total gastrectomy, the same surrounding structures are removed, plus the spleen and any involved resectable organs such as liver, pancreas, transverse colon or diaphragm (Fig. 3&4, A&B). Only in exceptional cases is the transthoracic approach combined with the trans-abdominal.

For a number of years past, physicians in Hawaii have been impressed by the frequency with which carcinoma of the stomach occurs in Japanese, who represent approximately 40 per cent of our population. To determine what this incidence might be as related to operations for gastric and duodenal ulcer and gastric cancer occurring in our various races, a study of 500 operations performed by me for these conditions was made. Comparison of these various operations among the different races showed that only the Japanese differed materially. Approximately 40 per cent of the operations were done in Japanese, and 60 per cent in other races. In the mixed races (not including Japanese) 41 per cent of the operations were done for duodenal ulcer; 27 per cent for gastric ulcer; and 31 per cent for gastric cancer. The Japanese race showed 17 per cent for duodenal ulcer, 21 per cent for gastric ulcer; and 62 per cent for gastric carcinoma (Table 4). Thus, operations for gastric carcinoma were twice as common in Japanese as compared to other races

FIG. 3.—Total gastrectomy for carcinoma including a portion of the duodenum and terminal esophagus. Also spleen, omentum, gastrohepatic mesentery and involved diaphragm about the cardia.



A



B

FIG. 4.—Total gastrectomy for carcinoma. A. Anterior view. B. Posterior view to show the involved transverse colon resected with the stomach.



FIG. 5.—A. Penetrating ulcer, lesser curvature of stomach, 1943, probably benign. B. Inoperable carcinoma of the stomach (same patient) five and a half years later.

TABLE 4.—*Comparison of benign and malignant gastric lesions found in Japanese and in races other than Japanese.*

500 cases—all nationalities—operated upon for gastric or duodenal ulcer or gastric carcinoma.	
Approximately 300 cases (60%) mixed races.	
200 cases (40%) Japanese	
Mixed races	Japanese
41% duodenal ulcer	17% duodenal ulcer
27% gastric ulcer	21% gastric ulcer
31% gastric carcinoma	62% gastric carcinoma

while in non-Japanese, operations for duodenal ulcer occurred two and a half times more frequently. In Japanese, 22.8 per cent of the carcinomas occurred in females and 15.5 per cent occurred in females of other races.

It is impossible to determine with any degree of accuracy what percentage of benign ulcers of the stomach ultimately become malignant. In this series, 24.9 per cent of the patients gave a history of stomach trouble for one year or more and in 18 per cent the history extended over a period of two or many years. It was our belief in several cases, at least, that in all probability the original trouble was a benign lesion and as an example, the following brief case report is presented.

#### Case Report

A Japanese male, age 41, seen in August, 1943, with stomach trouble of many years' duration, was advised to have a gastric resection because of a penetrating ulcer on the lesser curvature of the stomach. A gastric analysis showed a pH of 1.2 and 4 plus free hydrochloric acid. The advice

was not heeded and he was next seen five and a half years later with a palpable epigastric mass. X-ray showed an extensive involvement of the stomach. Gastric analysis showed total acidity, 0. At operation, the central portion of the carcinomatous tumor was in the region of the ulcer crater visualized five and a half years previously, and the condition was entirely inoperable (Fig. 5 A&B).

In passing, it is of interest to note that carcinoma of the breast occurs very rarely in our Japanese women though carcinoma of the cervix and reproductive organs is not at all infrequent in this race. At the moment we have no explanation for this variation in malignant lesions in Japanese.

The high incidence of malignancy occurring in association with ulcerating lesions of the stomach in Japanese has for many years made us very reluctant to treat expectantly anyone of this nationality with such a condition. With increasing experience, we have gradually become unalterably opposed to the medical treatment and observation of any ulcerating lesion of the stomach in anyone of any age who is a reasonable surgical risk. When one considers that a high percentage of ulcerating lesions of the stomach when first seen are malignant; that there is at present no known method of differentiating between benign and malignant ulcers at a time when surgery has the most to offer; that frequently only by the microscope can



this differentiation be made; that many patients with chronic gastric ulcers suffer from hemorrhage, perforation, and recurrent episodes of medical care; and that gastric resection for benign gastric ulcers in competent hands is a most satisfactory procedure, what logical excuse can anyone offer for treating such lesions conservatively?

This study in common with all others that have come to our attention offers a depressing outlook for the individual with cancer of the stomach. It continues to be our belief, however, that all individuals with such a lesion should be explored unless contra-indication exists, for only by surgery can the individual hope to long survive and a sufficient number of five-year survivals or longer are obtained to justify radical surgery. By earlier

diagnosis and the general adoption of more radical surgery by those adequately trained in abdominal surgery, no doubt, survival statistics can be improved. We wish particularly to stress the belief that all ulcerating lesions of the stomach are surgical problems, once the diagnosis has been established. The spread of malignant cells from the primary focus in this condition undoubtedly occurs much earlier than it occurs in most similar lesions encountered elsewhere. Time is a vital factor that should not be consumed in medical experimentation, a fact that has been difficult to impress upon some of our medical colleagues, and I am sorry to say is not appreciated by some of our surgical brethren.

1020 Kapiolani St.

## The Modern Psychiatric Hospital

DANIEL BLAIN, M.D.

WASHINGTON, D. C.

IT IS AN accepted truth that no demand makes itself known until there is reason to believe that some response can be expected.

By this token, the insistent demand for more complete psychiatric services is proof that the public believes that medical science now has something to offer to the mentally diseased.

This building and the services that it is built to maintain are a demonstration that great progress has been made. Already the rapid discharge and high turnover rate show that more than ordinary services are being performed in this hospital. The splendid work of the staff here is an example to other hospitals.

All these things have not always been so. The first hospital treatment for mentally ill in our country was at the Pennsylvania General Hospital and was followed shortly by the first hospital for mentally ill alone at Williamsburg, Va., both in the 1780's.

Since that time, approximately 198 State and

Territorial hospitals have been built, besides more than 60 special institutions for mentally defective and epileptics. In addition, our Federal Government in its various branches has built and is operating something like 35 large mental institutions. So that there are some 300 hospitals for this group of patients, un-

der Federal or State or Territorial care. In addition, there are listed some 1100 private hospitals, most of which are small, many better designated as nursing homes under medical supervision.

Most of these hospitals are large structures, differing from general medical and surgical hospitals in several important ways. First, they are larger, rarely under a thousand patients, and running up to the largest in the world, the Pilgrim State Hospital in New York with its 13½ thou-



DR. BLAIN

\* Speech delivered by Dr. Daniel Blain, Medical Director of the American Psychiatric Association, Washington, D. C., at the dedication of the new Treatment Center at the Territorial Hospital on May 20, 1950.



sand, followed by Milledgeville, Georgia, with its 121½ thousand. The smallest has 361 and is in Nevada with its 168,000 population. The great majority have two to four thousand patients and 300 to 1500 members of the staff.

They differ also in the length of time the patients remain. This factor is responsible for the fact that over 50 per cent of all hospital beds are used by mental patients. We must not draw the conclusion that 50 per cent of all people come down with mental illness, nor that 50 per cent of patients entering hospitals or doctors' offices are mentally ill. Figures from the Veterans Administration will illustrate my point. Whereas 57 per cent of beds were devoted to mental cases, only 12 per cent of admissions were for this cause. Relatively few methods of treatment have been available in the past. Because of our inability to overcome the disease process, patients stay many years. The average age of patients has risen with the passing years until in many State institutions over half of the people are over 65 years of age. In one typical Veterans Hospital, 11 per cent of patients have been there over 20 years, another 11 per cent over 15 years. In a big State hospital in Oklahoma, 15 patients had entered when the hospital was opened in 1908 and have now been there 43 years.

These 300 large mental hospitals have each been built to offer the best that medicine had to offer at the time. But the best was only a good brand of custodial care—care of the body only—little was known about methods to induce recovery. The construction of a building dedicated to treatment is a great event in the history of mental institutions. It is a monument to psychiatric progress.

The lack of medical skill to produce cure, and the strange and bizarre behavior of mental patients, when viewed without understanding by relatives and acquaintances, and the placing of such institutions in far off places have resulted in a scientific, physical and spiritual isolation which has always in the past slowly worn down periodic attempts to maintain high standards of care, and helped in neglect of the needs of the patients. Physicians working in mental institutions have grown away from our colleagues in the profession perhaps chiefly because they are so overcome by the administrative burden of an overwhelming load that they forget they are physicians. Yet, the faithful, persistent efforts of the small group of devoted personnel who have not deserted these forgotten patients, form one of the great chapters in the history of our profession. After visiting about two hundred of our big public hospitals,

short of staff and with small appropriations, I can report to you that in not one did I fail to find at least a small corner where some excellent medical work was being practiced.

But the effort to take care of this increasing burden of mental patients has been until very recently a losing fight.

Statisticians say there is no relative increase in mental disease needing hospitalization. The figure of 1/3 of one per cent of a population has remained unchanged in a hundred years. By this token, you have a healthy mental climate in the Islands for 1/3 of one per cent would call for 1800 beds, and yet 1100 seems to be enough. But the increase in population has brought about an absolute increase in numbers, and greater recognition and less ability on the part of people to look after their own has created a demand on existing hospital facilities that is staggering. Overcrowding from 30 to 60 per cent is the rule. Understaffing in all categories of trained personnel is found everywhere. Shortage of funds reflects the lack of public support in most States and Territories.

The hospital today is not the only focus of effort. But it remains the center. It takes its place in treatment programs, in the preventive medicine program along with the health department, the mental hygiene program and the mental health program to build strength and maturity into people and their relation with each other.

The hospital must provide new techniques of diagnosis and treatment. This includes our orderly arrangement to care for the incoming patient, and also to screen the intake to ensure the admission of only those who properly belong here. This suggests that there may be need for other institutions for those that are brought to mental hospitals because no other place exists. The most common example of this is the victim of the aging process—which sooner or later hits us all. The aging person who may have trouble in seeing or hearing, in his digestion, may be weak or cannot sleep, has occasional loss of memory, is querulous and easily excited, cannot look after himself, has a weak heart or stiffening joints; who can blame them for being occasionally a bit mental as well? But they are not primarily mental patients—they do not belong in a mental hospital. The increasing number of these people require serious consideration on the part of medical and social planners. Both public and private care for these people are needed.

Others also do not belong in a mental hospital. The benign psychoneurotics, or anxiety states, do not do well in the long run in a mental hos-

pital—but those who come need not be locked up. This hospital is to be congratulated on the seven hundred out of eleven hundred who are in open wards out here.

Modern treatment technics require more small treatment and interview rooms, competent and available surgery and neurosurgery, and other specialties. The institution as a whole must be in itself a therapeutic tool so that coming into it gives the patient a feeling of confidence, friendliness, hope and desire to get well. The hospital must provide the opportunity to visit with others, mixing of the sexes when possible, treatment of all aspects of the patient's needs, especially the social and spiritual. Constant effort on the part of everyone to keep the patient moving towards recovery is reflected in the expression "Total Push," which is not new; it was used by Meyerson in 1934. This means to place at the disposal of the patient good food, rest, exercise, recreation, occupational activities that suit him, vocational stimulation and training, a personal and social push to improve. It must be associated with proper technical psychiatric treatment—with such therapies as the latest medicines, insulin, specific vitamins, physical treatments, such as baths, massage, muscular exercise, physiotherapy—hot and cold stimulation; electricity in doses of shock and sub-shock, psychological treatment in interviews, groups and individual psychotherapy, with and without sleep producing injections. There is the application of modern rehabilitation methods especially for long term patients—with its elaboration of occupational therapy, vocational training and guidance, educational classes. There is the application of social forces by patients in contact with each other, who push and pull each other into making faster progress. This is reflected in the modern principle of group therapy, possibly the greatest contribution of the last few years. There is the application, on the part of the whole working force, of knowledge, skill, judgment, fairness, firm and loving interest to the patient group and also control and the support of the timid patient ready to go home but fearful of the ordeal. And there is careful nurturing of family relationship throughout the hospital stay and the preparation of the folks at home to receive the homecoming patient and make things neither too hard nor too soft to suit the needs of a recuperating spirit.

The hospital must play its part in out-patient care, and work closely with all mental hygiene efforts. It may lend its staff to community clinics, to follow-up of its patients, and to helping in family adjustments.

The hospital must exert leadership in spreading information about personality needs, in working with teachers, parents, industrialists and labor leaders, the courts, the journalists, civic organizations, service organizations, women's clubs. It will do all this in close association with physicians in other hospitals, with psychiatric units in general hospitals, the medical societies, and other institutions and private practicing physicians, and with Mental Hygiene Society and other citizen groups.

But this beautiful structure with its functional arrangement, its color, its convenience, its happy menage to unhappy people cannot operate by itself. As a kitchen without food, so a pile of brick and mortar and concrete, wood and glass and paint, cannot function without its staff.

Personnel are both the glory and failure of modern medical institution. When the staff is short-handed, not properly trained, poorly administered, without motivations, treated like animals, and robbed of self-respect, the finest buildings and gayest colors will be but a mockery to the taxpayers' money.

The willingness of appropriating bodies to build monuments to themselves and then fail to provide sufficient personnel and operating expense is one of the commonest examples of political malpractice. The lifelong sentences which accompany so many patients to mental hospitals are the greatest extravagances that could be inflicted on the pocket-books of gullible voters. The fifteen patients who entered the hospital in Oklahoma in 1908 and remained there 43 years have cost the taxpayers at \$1.25 a day, \$293,281.25 and they are still there. And for what? For keeping these people unhappily alive and nothing more, contributing nothing to the welfare of themselves and their families.

Disease is the most expensive luxury a community can tolerate. The mental hospitals of the United States spend for care of their patients over one billion dollars a year, and the loss to family incomes and loss of production amounts to another billion. The cost of mental health is high but it is a bargain in terms of the factor to provide mental health.

This hospital discharges 510 patients a year. At the rate of say \$1.50 a day or \$550.00 a year and with a life expectancy of 25 years, each of these patients not sent home would cost the taxpayers \$13,750.00. And 510 discharges and conditional discharges mean a savings of \$7,012,500.00. That is at the low rate of \$1.50 a day, which pays for no treatment and poor custodial care.



Under the competent leadership of your superintendent, the newly admitted cases are averaging only 120 days or 4 months stay in the hospital. At the new rate of \$3.50 a day, the cost per patient is \$420.00 for the entire stay. Compare the financial savings of \$420.00 cost per patient with the cost of \$13,750.00 a patient where they get only poor, custodial care.

I feel like the worst kind of materialist when I talk so much of money, for the increased hope and contentment and confidence and optimism and security and self-reliance of people who are mentally healthy cannot be measured in terms of dollars. But the taxpayers' money can only go so far and due economy must be practiced. In the face of a falling economy, we must have good reasons to ask for an increase in appropriations.

The staffing of a mental hospital is a difficult problem. Every professional, every trained and untrained person, from the superintendent to the gatekeeper and night watchman, plays an important part in the treatment of the patient.

Psychiatrists and other medical specialists are short in supply. The same is true of psychiatric social workers, clinical psychologists and our oldest associate, the nursing profession. Institutional work will not attract the best people unless there is a chance for professional satisfaction in the work that can be done—a chance to learn, to advance, to make progress, to see some glimmer of hope for the future, to participate in some of the newer methods as they develop.

There must be training in all categories for nothing stimulates the inquiring mind like participating in the learning process. And most of the trained personnel will have to come from the in-service training program of the hospital itself.

There must be research of all types going on. Dr. Allen Gregg of the Rockefeller Foundation says there are three kinds of research. A study which is a review for your own work to evaluate it—a survey which includes a broader study of all work in a given field and pure research in which a hypothesis is presented and either proved or disproved.

The list of trained personnel who assist in a well staffed hospital point to the complexity of human nature. We use occupational therapists, recreation directors, physical educators, chaplains, technicians, librarians, corrective muscular therapists, physiotherapists, educational and vocational teachers, dietitians, and assistants in the kitchen, on the farm, on the grounds and to operate the machinery. We need records, record clerks and secretarial assistance. Two great groups of people, the attendants, now called psychiatric aids, and the volunteers can be trained to fill in to help in almost all of these categories. Perhaps we can say that the largest group of all, the attendants, offer perhaps the greatest hope. They are nearest to the patient, spend more time with him and carry out most of the orders from higher up.

In a cooperative community such as this hospital, many of these functions are carried by the same people. Doubling up and sharing responsibilities are a common practice.

A modern hospital is as complicated as a modern battleship. It may work perfectly or it may be a poor investment of efforts or money. It should be flexible and wholly dedicated to just one thing—the diagnosis and treatment and the prevention of mental illness and should take the lead in the program for mental health.



# Rheumatic Fever in Hawaii

ANGIE CONNOR, M.D. AND TERUO YOSHINA, M.D.  
HONOLULU, T. H.



DR. CONNOR

IN recent years, it has become evident that rheumatic fever occurs in tropical and subtropical climates.<sup>1</sup>

In Hawaii, the first case of rheumatic fever of the classical acute form with fatal cardiac involvement was reported in 1941 by Doolittle and Tilden.<sup>2</sup> In discussing this paper, Gotshalk reported that in 1936 he saw a 16 year old Portuguese girl die of subacute bacterial endocarditis due to streptococcus viridans. She had her first rheumatic attack in 1933. At autopsy Aschoff bodies were found in the heart muscle. In 1949 Berk and Hartwell<sup>3</sup> reviewed the medical records of four Honolulu hospitals covering the five year period from 1942 through 1946 and found that rheumatic heart disease was present in 17 per cent of the total cardiac cases; they concluded that rheumatic infection was not uncommon in Hawaii.

In 1947, in view of the above evidence that rheumatic fever existed in the Territory, a rheumatic fever program was started at Kauaikeolani Children's Hospital in Honolulu. It is our intention to review the first two years of this program and to contrast rheumatic fever as seen here with that occurring in the temperate zone.

Children between the ages of 4 and 15, from the island of Oahu only, were admitted for acute and convalescent care, and a rheumatic fever clinic for diagnosis and follow-up was organized. Seventy-three patients were observed under this program from November 1, 1947 to November 1, 1949. This constituted 1.2 per cent of the total

admissions to the hospital. Thirty-two (44 per cent) were male and forty-one (56 per cent) were female patients. The racial distribution of the cases is illustrated in Table 1. The column on the far right shows the expected incidence in racial groups on the basis of their distribution in the population.

TABLE 1.—*Racial distribution of rheumatic fever cases in our series.*

RACE	TOTAL CASES	PERCENT OF TOTAL CASES	RACIAL PERCENT OF TOTAL POPULATION
Part-Hawaiian.....	26	35.6	14.2
Pure Hawaiian.....	13	17.8	2.0
Japanese.....	10	13.7	34.4
Filipino.....	9	12.3	10.0
Puerto Rican.....	4	5.5	1.9
Samoan.....	2	2.7	.....
Caucasian.....	4	5.5	29.8
Chinese.....	1	1.4	5.9
Korean.....	1	1.4	1.4
Filipino-Japanese.....	1	1.4	.....
Japanese-Caucasian.....	1	1.4	.....
Portuguese-Filipino.....	1	1.4	.....

(Part-Hawaiian represents mixtures of Hawaiian with Chinese, Caucasian, Japanese, Portuguese, Korean, or Filipino, or with combinations of these.)

A past history of rheumatic fever was obtained in 33 (45 per cent) of the cases. The average age of onset of the first attack in those children with a previous history was 8.9 years, whereas the age of admission of the total group coming under the care of the program was 9.9 years, as contrasted with an average age of onset in most mainland clinics of 6 to 7 years.<sup>4</sup> In 15 children (20.5 per cent), the month of onset of the disease was unknown. In those cases where the onset could be dated, all months were represented, with March and July predominating.

Auscultation of the hearts as of November 1, 1949 revealed that apical systolic murmurs were heard in 26 (35.6 per cent); aortic diastolic murmurs in 10 (13.7 per cent); 11 (15 per cent) had combined mitral systolic and mitral diastolic murmurs; 6 (8 per cent) had mitral systolic murmurs and aortic diastolic murmurs combined and 2 (2.7 per cent) had mitral systolic, mitral diastolic and aortic diastolic murmurs. Eighteen children (24.6 per cent) had no murmurs. Pericar-

<sup>1</sup> Francisco, R.: Rheumatic Heart Disease in the Tropics with Special Reference to its Incidence in Puerto Rico, Clinics 5:971 (December) 1946. Hardgrover, M., Whittier, L., and Smith, E. R.: Rheumatic Fever on the Isthmus of Panama, J.A.M.A. 130:488 (Feb. 23) 1946. Wilens, S. L., Pearce, J. M., and Fallas Diaz, M.: Relative Incidence of Rheumatic Valve Disease in New York and Costa Rica and Its Bearing on the Rheumatic Origin of Calcareous Aortic Stenosis, Am. Heart J. 30:573 (December) 1945.

<sup>2</sup> Doolittle, S. E., and Tilden, I. L.: Rheumatic Heart Disease in Hawaii, HAWAII MED. J. 1:7 (September) 1941.

<sup>3</sup> Berk, M. E., and Hartwell, A. S.: Five Years of Heart Disease in Hawaii, HAWAII MED. J. 8:177 (January-February) 1949.

<sup>4</sup> Wilson, M. G.: Heredity and Rheumatic Fever, Am. J. Med. 2:190 (February) 1947. Paul, J. R.: Epidemiology of Rheumatic Fever, Am. J. Med. 2:66 (January) 1947. Ash.<sup>5</sup>

<sup>5</sup> Ash, Rachel: The First Ten Years of Rheumatic Infection in Childhood, Am. Heart J. 36:89 (July) 1948.

TABLE 2.—*Symptoms and signs encountered in our series of 73 cases.*

Joint Involvement .....	47 cases		
Pain .....	47		
Polyarticular .....	42		
Swelling .....	20		
Heat .....	13		
Monarticular .....	5		
Redness .....	2		
Fever .....	54	Weight loss .....	8
Fatigue .....	22	Chorea .....	7
Malaise .....	21	Aching muscles .....	4
Nosebleeds .....	20	Rash .....	3
Pallor .....	19	Dyspnea .....	2
Anorexia .....	17	Sore throat .....	1
Abdominal pains .....	12	Nodules .....	0

ditis was diagnosed on clinical grounds in 3 children (4 per cent). Four children (5.5 per cent) had cardiac failure, and 3 (4.1 per cent) had rheumatic pneumonia, proved in 2 at post mortem examination. Subacute bacterial endocarditis occurred once (1.3 per cent). Four (5 per cent) of the 73 children died during the two years of the program. Sixteen (22 per cent) of the children have already had a recurrence in the two years period of observation.

A summary of the pertinent laboratory data is found in Table 3. Of the 58 patients (80 per cent) already discharged from the hospital, the average length of stay was 126 days. Of 15 patients (20 per cent) still in the hospital as of November 1949, the average period of hospitalization was then 176 days.

TABLE 3.—*Laboratory, electrocardiographic and roentgenologic findings.*

Laboratory Work	CASES
Elevated erythrocyte sedimentation rate.....	73
White blood count above 10,000.....	32
Hemoglobin (below 70%).....	17
Electrocardiogram	
Prolonged P-R Interval.....	17
Fibrillation .....	1
Fluoroscopy	
Abnormal .....	29
Normal .....	34
Not done .....	10
Roentgenogram of chest	
Cardiac enlargement .....	26

### Discussion

The predominance of Hawaiian and part Hawaiian children in our series was significant, and was out of proportion to their numbers in the general population.

In a large percentage of cases (20.5 per cent), the month of onset was not known, apparently because of the insidious type of onset. On the contrary, Ash<sup>5</sup> reported from Philadelphia that only 8 per cent of her cases had an insidious onset with carditis as the major manifestation. The difficulty in diagnosing this type of case until relatively late may adversely influence the prognosis of our cases.

Chorea, reported by Ash as initiating the disease in 19.6 per cent of her cases, occurred in only 7 (9 per cent) in our series.

Although 47 (64 per cent) of our children had joint manifestations, redness and heat were not common, and we got the impression that the joint manifestations, when they did occur, were not as severe as in temperate climates.

It is interesting to note that only 14 per cent of our patients gave a history of sore throat preceding the acute rheumatic attack. In a series of rheumatic children from Virginia reported by McCue<sup>6</sup> almost half of them had a sore throat before their rheumatic episode. In the territory to date, no study relative to the prevalence of hemolytic streptococci in the throats of rheumatic children has been done.

No rheumatic nodules were recognized, and only 3 patients had erythema rheumaticum.

Carditis was the most prominent manifestation, and valvular lesions tended to be common and severe. Several children reporting for examination because of weight loss and pallor, already had severe carditis, which apparently had been present for many months.

The percentage of recurrence in a two year follow-up period was high. Sulfonamide prophylaxis was used in only 8 patients. None of these has had a recurrence so far. Oral penicillin prophylaxis has been started too recently to warrant any statement of its efficacy in preventing rheumatic recurrences.

Of the 4 children who died, one had had numerous attacks of rheumatic fever and had auricular fibrillation and mitral stenosis. One patient died of sub-acute bacterial endocarditis, and 2 children died following an acute primary carditis, complicated by rheumatic pneumonia.

### Conclusions

1. Rheumatic fever is common in Hawaii.
2. Hawaiian and part-Hawaiian children appear to be particularly susceptible.
3. An insidious onset with carditis is common, and joint manifestations are relatively mild.
4. Rheumatic nodules were not found in our series.
5. The rate of rheumatic recurrences is high.
6. Cardiac enlargement and valvular lesions are common sequelae.

<sup>6</sup> McCue, C. M., and Galvin, L. F.: A Preliminary Report on Rheumatic Fever in Virginia, *J. Pediat.* 33:467 (October) 1948.



# Subdural Hematoma

## Complications and Surgical Treatment: Report of 51 Cases

RALPH B. CLOWARD, M.D.

HONOLULU

**H**EMORRHAGE beneath the dura as a result of trauma is one of the oldest pathological afflictions of the nervous system described by man. The first recorded case, described by Ambroise Paré in 1560, was that of King Henry II of France, who died as a result of a supraorbital wound received in a tourney. A classical description of the histopathology by Virchow was published in 1857, and successful surgical removals of "blood clots from the surface of the brain" were reported by Ball and Schneider in 1888 and Macewen in 1889. An excellent review of the early literature was included in the paper on chronic subdural hematoma published in 1925 by Putnam and Cushing. Since that time authors, including Munro, Horrax and Poppen, Davidoff and Dyke, Peet, Merritt, Ingraham and Matson, Naffziger and Brown, and many others have contributed to our thorough knowledge of clinical and pathological analysis of the subdural hematoma.

It is the purpose of this communication to review briefly the pathology, clinical manifestations and treatment of the three types of subdural hematoma, to describe various fatal complications which may be caused by the subdural hematoma and give a brief statistical report on 51 personally treated cases.

There are two types of subdural hematoma, the acute and the chronic. The two forms differ not only in their pathology but also in their clinical symptomatology and prognosis.

### Acute Subdural Hematoma

The acute subdural hemorrhage is the result of severe head injury and may be combined with skull fracture and extensive brain damage. They make up from 1 to 10 per cent of all head injuries. Only those cases showing symptoms a few hours after the injury are included in the acute variety. The hemorrhage results from a violent blow to the head which may so dislodge the intracranial contents as to tear the large veins on the surface of the brain as they enter the venous sinuses. This type of hemorrhage is seen in boxers and football players. The skull may be fractured and the brain lacerated and/or severely contused.

Blood fills the subdural and subarachnoid space uniformly over the surface of the cerebral hemispheres and about the base of the brain.

There is no clinical symptomatology which is definitely characteristic of acute subdural hematoma. Helpful diagnostic signs of acute hemorrhage are:

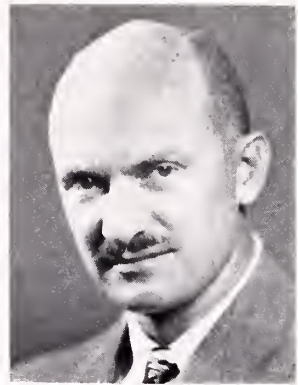
1. Head injury followed by increasing headache, drowsiness, blurred vision, mental confusion, and rapid or progressive lowering of the level of consciousness to stupor and coma.

2. Dilatation of the pupil on the side of the hemorrhage. This is not diagnostic but when present may indicate severe unilateral increased intracranial pressure. Pupillary dilatation is due to pull of the third nerve against the free border of the tentorium or to hemorrhages in the midbrain. Bilateral pupillary dilatation is recognized as ominous, its presence usually means a fatal outcome.

3. Changing rigidity in all extremities, with the final picture of bilateral decerebrate rigidity. This also is a grave prognostic sign, indicative of irreparable damage to the vital centers of the midbrain. The more rapidly these clinical signs develop, the higher the mortality rate.

Lumbar puncture is not helpful as a diagnostic aid and may be dangerous. The pressure may or may not be increased. The fluid is usually bloody in the early stages and yellow later. Respiratory paralysis may result from medullary compression if the intracranial pressure is high.

Roentgenograms of the skull are likewise useless as a diagnostic aid and may do the patient harm out of proportion to the information gained by them. A fracture line may or may not be present; if found, it will not differentiate subdural hematoma from other types of brain damage. A displaced calcified pineal body is not helpful in recognizing a hematoma, since this finding may be present with unilateral cerebral edema.



DR. CLOWARD



The only diagnostic procedure of any real value is exploratory trephine openings in the skull. Too much emphasis cannot be placed upon the imperative need for early recognition of subdural hematoma. When the diagnosis is suspected, cranial trephine under local anesthesia, the simplest of all neurosurgical procedures, should be carried out without hesitation. Burr holes are made in the frontal and posterior parietal areas of the skull, bilaterally. The dura is tense and blue, and when it is opened a gush of dark venous blood with currant-jelly clots escapes under marked pressure. The blood is washed out of the subdural space with large quantities of normal saline solution through a catheter.

Early recognition and evacuation of such a hemorrhage may be life saving; however, the mortality in the *acute* subdural hemorrhage is very high. Echlin recently reported 9 deaths in 10 cases operated upon within the first twenty-four hours after injury. In my series 6 out of 9 patients died within the first forty-eight hours after injury; the average mortality is about 78 per cent.

#### Subacute Subdural Hematoma

The subacute subdural hematomas are those patients who regain consciousness following the acute head injury but who remain drowsy and listless, are disoriented and mentally confused and show signs of progressive cerebral dysfunction over a period from two days to about three weeks. These patients may develop a progressive hemiparesis, unequal reflexes, positive Babinski signs, a unilateral dilated pupil, papilledema or convulsions. Diagnosis of a subacute subdural hematoma may be suspected by findings of increased spinal fluid pressure, plus a shift in the pineal calcification shown on x-rays of the skull; it can be made, however, only by an exploratory trephine.

At surgery a thin subdural membrane may be found about the hematoma. The hematoma is usually a reddish-brown gelatinous clot or dark brown liquid. The size of the hematoma may be small or may be very large, displacing half of substance of one cerebral hemisphere. After removal of the hematoma through trephine openings the brain usually fills out, obliterating the large subdural space. This may be helped by injecting normal saline into the spinal canal. The average mortality of this group of cases is about 25 per cent.

#### Chronic Subdural Hematoma

The chronic subdural hematomas are most frequently found in infants and the aged. Unlike the acute and subacute variety, in the majority of

chronic subdural hematoma cases, trauma—that is, the actual head injury—is so insignificant as to be usually forgotten by the patient and thus may be overlooked in the clinical history. In children, birth injury or minor falls, often forgotten by the parents, may be responsible for the subdural bleeding.

The pathology of the chronic subdural hematoma has received considerable study since Putnam's classical description in 1925. These hematomas are most frequently found in the parietal region, are bilateral in one-third to one-half of cases, and are always enclosed in a capsule. The walls of the latter may be tissue-paper thin or over a centimeter in thickness, and may be calcified. The contents varies from reddish-brown gelatinous clots or granular partially organized blood to syrupy yellow fluid. Microscopically, the membrane is found to be composed of young fibroblasts and capillaries, arising from the under surface of the partially organized clot. This forms a layer of granulation tissue. The new fibroblasts form collagen and develop into mature connective tissue cells—the membrane proliferates to completely enclose the blood clot forming a sac. The hemorrhage may become arrested, the clot organize and the hematoma remain on the surface of the brain for years without giving symptoms. More often, however, it continues to increase in size, giving signs of increasing intracranial pressure. The gradual increase in size of the hematoma after the bleeding has stopped has been shown to be due to osmosis. The thin capsule acts as a semipermeable membrane, the broken-down blood within having a higher protein concentration than either blood or cerebrospinal fluid outside the membrane. Fluid passes through the membrane from the lesser to the greater concentrations, thus increasing the size of the hematoma sac. This process is especially seen in children, who may develop enormous sacs of fluid over each cerebral hemisphere, enlarging the head to a considerable size. A diagnosis of hydrocephalus is almost always made in these cases.

The symptoms of the chronic hematomas vary widely. They may be grouped into (1) those caused by general increased intracranial pressure; i.e., (headache, vomiting, vertigo, slow pulse, choked disc), (2) those due to local pressure on the brain (motor paralysis, aphasia, hemianopia, convulsions, etc.) and (3) those caused by irritation (stiff neck, Kernig's sign, etc.).

It should be stressed that the extreme variability of symptoms is in itself diagnostic. Mental confusion and psychotic states are frequently observed, especially in the aged. In infants, convul-

sions, failure to do well, hyper-irritability, refusal of food, or accelerated increase in head size should be seriously considered as due to subdural hematoma—especially with a history of difficult labor or delivery.

Diagnosis can best be made by roentgenograms of the skull showing calcification in the hematoma wall or a displaced pineal body, or roentgenograms of the brain by encephalogram or ventriculogram. Exploratory trephine and washing out the contents of the subdural sac with diluted water is usually the only treatment required. However, a craniotomy operation is frequently necessary in these cases when the capsule is very thick, preventing the brain from filling out and obliterating the subdural sac. The prognosis is better and the results of surgical intervention are far more satisfactory in the chronic subdural hematoma cases than in the other varieties. The difference in prognosis is probably due to the degree of concomitant damage to the brain. In the acute subdural hemorrhages the trauma is of great severity and frequently associated with diffuse, severe injury to cerebral tissue; while the trauma in the chronic variety is usually mild or of no significance.

### Complications

The complications of subdural hematomata have received little attention in the medical literature. By complications we mean the secondary pathologic processes which develop as a result of or in conjunction with the hematoma. These complications may be responsible for a fatal outcome in a patient who could have been expected to recover from the treatment of the subdural hematoma alone, or if he survives, he may be seriously handicapped physically or mentally.

In reviewing my series of 51 subdural hematomas which I have operated upon in the past ten years, we have found the following complications:

(1) Infection—a primary, blood-borne infection in the hematoma. Four cases, all in children, had positive cultures from the contents of the hematoma, 2 were *E. coli*. Two of the 4 died.

(2) Acute hemorrhages in the midbrain following evacuation of a large unilateral chronic hematoma. Death from this complication is thought to be due to sudden shift of the brain from release of marked unilateral pressure, and subsequent pressure upon the vessels about the midbrain by the free edge of the tentorium. One case admitted to the hospital in coma made a dramatic recovery after evacuation of the hematoma only to lapse back into coma and die three days later from this complication.

(3) Thrombosis of large cerebral arteries due to pressure by the hematoma. One recent patient, injured in a fight, developed a subacute subdural clot which was evacuated eleven days after injury. He lived three months and never regained consciousness. Autopsy disclosed an encephalomalacia of the entire lateral surface of the cerebral hemisphere, due to thrombosis of the middle cerebral artery.

(4) The fourth complication is not often fatal, but is often disabling. It is due to the mechanical effect of pressure on the localized area of the brain, with subsequent cortical atrophy. Whether the atrophy and scarring is just a pressure phenomenon, or due to an impairment of vascular supply, is difficult to say, since some cases with extreme pressure show little cortical damage while another, with less, may show extensive scarring. Nevertheless, we have had patients who developed intractable epilepsy two years after evacuation of a chronic subdural hematoma and children who became hemiplegic, mentally retarded and developed convulsions in later years. Because of this last complication, we have come to feel that more and more of the chronic hematomata should be surgically treated by craniotomy and complete removal of the capsule to obviate the development of the serious sequelae at a later date.

### Summary

A bird's eye view of the 51 cases of subdural hematoma I have operated upon here in Hawaii may be of interest.

The ages ranged from 3 days to 78 years.

There were 43 males and 14 females (males being more exposed to trauma).

Of the 51 patients, 43 are alive and 14 dead, an overall mortality rate of 32.4 per cent.

Of the 14 dead, 6 died within forty-eight hours of injury, death being due to accompanying severe brain damage.

The other 8 deaths were listed as: infected hematomata, 2; pneumonia, 1; coronary thrombosis, 1; midbrain hemorrhage, 1; cerebral edema, 2; cerebral thrombosis with encephalomalacia, 1.

Thirty-four patients were treated by trephine openings only with 9 deaths.

Fourteen patients treated by craniotomy with 5 deaths.

Three babies were treated by aspiration through the suture lines.

There were 22 cases in children under 14 years of age, 8 girls and 14 boys. Nineteen of these were treated by trephine with 3 deaths and 3 by craniotomy with 1 death (infected).



# Alternating Bidirectional Tachycardia

MORTON E. BERK, M.D. AND HENRY GOTSHALK, M.D.  
HONOLULU

**R**EPORTED electrocardiograms showing rhythmic alternation of the QRS complexes in cases of paroxysmal tachycardia are still few in number. With the one reported by Zimdahl and Kramer<sup>1</sup> there are 33 cases in the literature. Since there is considerable disagreement as to the mechanism of this bizarre tachycardia, it would seem important that all such cases be recorded. This case is being reported in an attempt to clarify further the underlying mechanism and to suggest that the prognosis in these cases need not be as gloomy as in the cases reported previously.



DR. BERK

## Case Report

Mr. W. E., a 51-year-old Hawaiian, was admitted to The Queen's Hospital April 7, 1945. He complained of ankle swelling and shortness of breath. These symptoms ante-dated his admission by a few weeks.

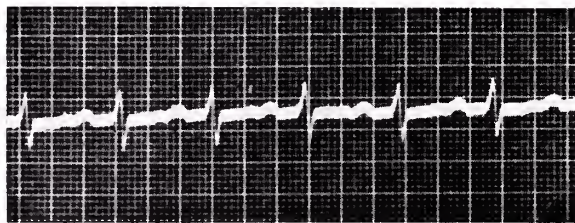


Fig. 1. This tracing shows a P-R interval of .24 sec. This record was made 3 days after his first admission in April 1945.

**Past History.** During August 1943 a senile cataract was removed from his left eye. At that time the hospital record shows that his blood pressure averaged 150/110. There was nothing more in his past or family history that was contributory to his present illness.

**Physical Examination.** Temperature 98° F.; pulse rate 110; respirations 22; blood pressure 218/172. The patient was dyspneic, orthopneic and edematous. There was a cataract in his right eye. In the left eye the fundus showed changes compatible with arteriosclerosis and grade II hypertensive retinopathy. Breath sounds were

Received for publication November 21, 1949. From the Department of Internal Medicine, The Queen's Hospital.

<sup>1</sup> Zimdahl, W. T., and Kramer, L. I.: On the Mechanism of Paroxysmal Tachycardia with Rhythmic Alternation in the Direction of the Ventricular Complexes, *Am. Heart J.* 33:218 (Feb.) 1947.

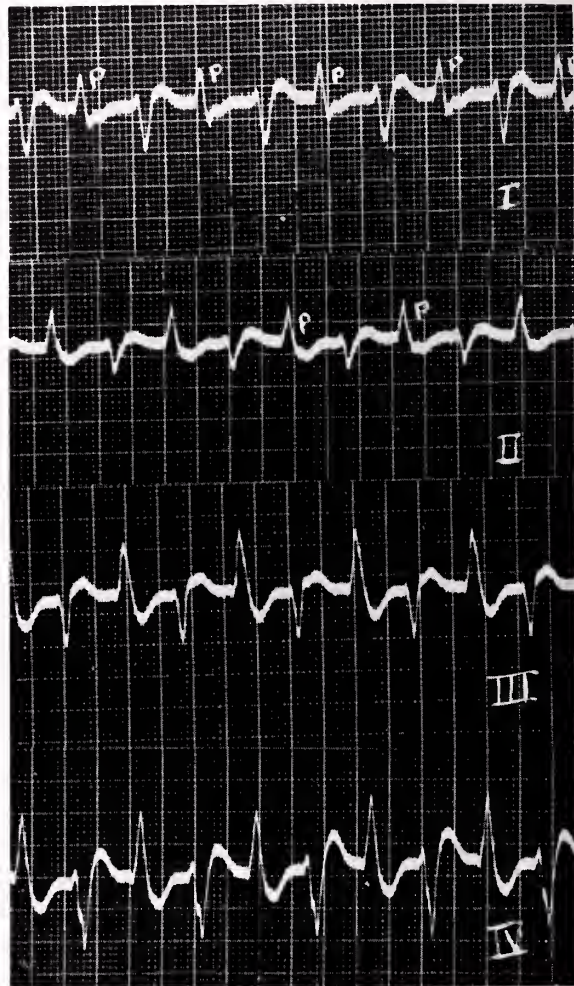


Fig. 2. Alternating bidirectional tachycardia. R-R interval measures the same as S-S interval. Small P waves are designated by a letter P. Note that the QRS complexes are less than 0.12 sec.

diminished over the right lung base, and coarse, moist rales were heard in this same area. The heart rate was rapid, the rhythm regular. P<sub>2</sub> was louder than A<sub>2</sub>. No murmurs were heard. The liver edge was rounded, tender and 5 cm. below the right costal margin.

Laboratory studies were made within normal limits. The diagnosis was hypertensive-arteriosclerotic cardiovascular disease with congestive heart failure. Rapid digitalization was obtained by use of 1.2 mgm. of digitoxin administered orally. A maintenance dose of 0.2 mgm. daily was changed to 0.1 gm. of powdered digitalis leaf.

The patient responded well to a regimen which included ammonium chloride, low sodium intake and ample bed rest. After one week he was discharged with



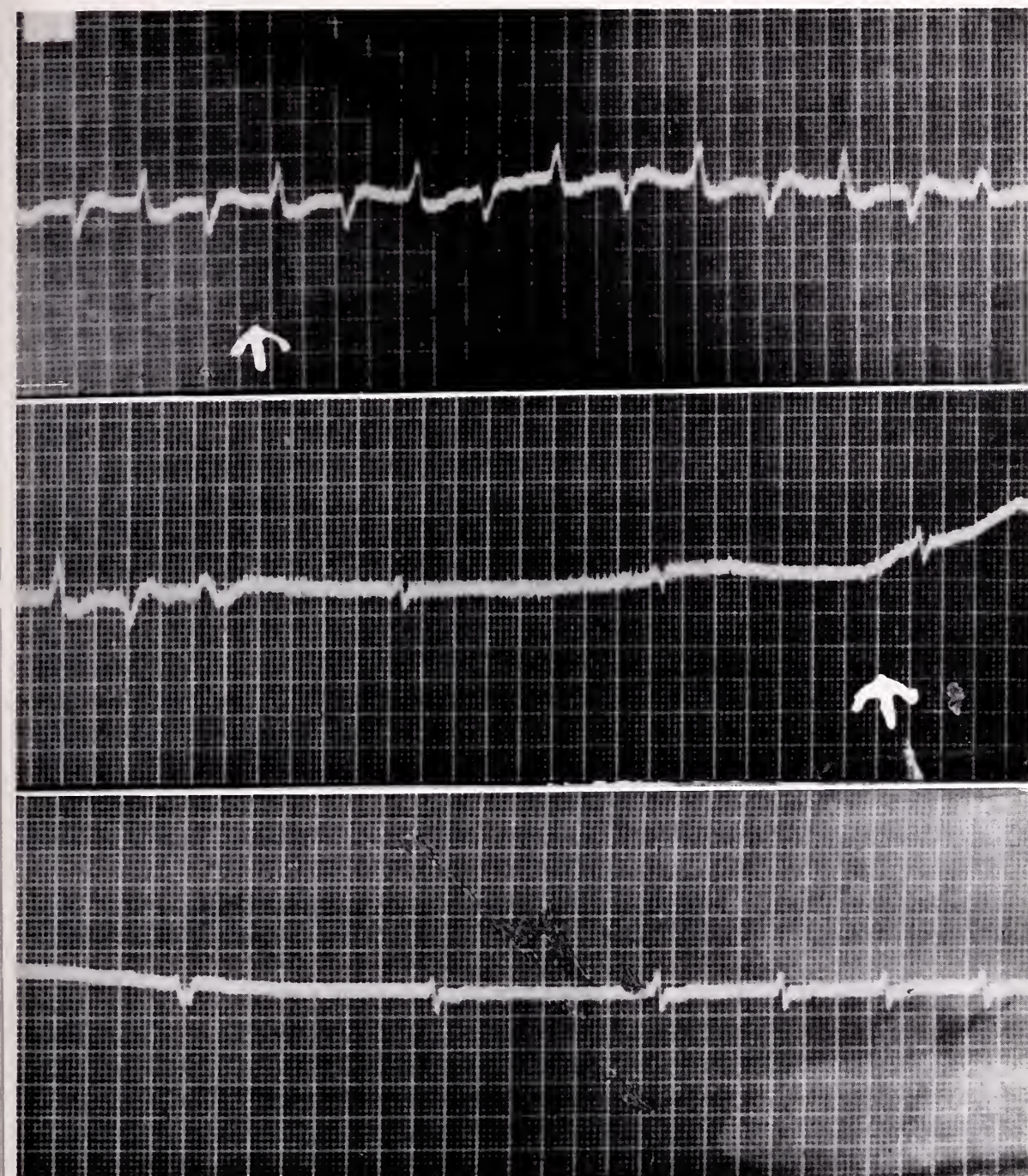


FIG. 3. This is a continuous record showing the change from the bidirectional tachycardia to a regular rhythm. First arrow marks point where right carotid sinus pressure was applied. Note long duration of almost complete cardiac arrest except for weak ventricular contractions. Second arrow marks point where carotid pressure was released. After resumption of regular rhythm, the record resembles that of Fig. 1.

a month's supply of digitalis. He was instructed to see his local physician on the island of Molokai for follow-up therapy. An electrocardiogram taken April 10, 1945, three days after admission and digitalization, showed left axis deviation; low diphasic T waves in the limb leads and a P-R interval of 0.24 second (Fig. 1).

On August 11, 1945, W. E. was readmitted because

of congestive heart failure. He had taken no digitalis for about three months. He was redigitalized with powdered leaf, advised as to his subsequent activities and follow-up and discharged August 17, well compensated.

The patient was again admitted January 23, 1946. Once more he had neglected to take digitalis for at least three months and he was in advanced heart failure. His



neck veins were distended; moist rales were heard over the bases of both lungs; and the liver edge was felt 8 cms. below the right costal margin. The heart rate was 160 shortly after admission, and this rate increased slightly. The rhythm was regular. With carotid sinus pressure, the rate dropped abruptly to less than 100, but it immediately returned to over 160 after pressure was released.

His urine showed a questionable trace of albumin and a specific gravity of 1.005. The N.P.N. was 30 mgm. per 100 cc.

He was given a sodium-free diet and 0.4 gm. of ammonium chloride daily. In addition he received 0.2 gm. of digitalis (powdered leaf) intramuscularly every 3 hours for 3 doses. After a lapse of 7 hours he was again given 0.2 gm. of digitalis intramuscularly. Shortly after this fourth dose an electrocardiogram was taken (Fig. 2). The heart rate had remained persistently rapid except during the time when carotid pressure had caused a drop in the number of beats per minute.

Digitalis, restricted sodium intake, unrestricted fluids and mercurial diuretics resulted in 40 pounds' weight loss the first week. Digitalization was maintained with 0.1 gm. daily of powdered leaf. An electrocardiogram (Fig. 5) taken January 31, 1946 shows a complete A-V dissociation. All subsequent electrocardiograms through March 1949 show auricular fibrillation with occasional ventricular extra-systoles (Fig. 6).

Since his discharge on February 16, 1946, the patient has taken his digitalis faithfully. During the late summer of 1946, contrary to medical advice, Mr. W. E. with two helpers moved houses and surplus army buildings all over the island of Oahu. In March 1947 he returned to his home on Molokai where he has persisted in doing light work. At intervals he has received mercurial diuretics which have kept him comfortable.

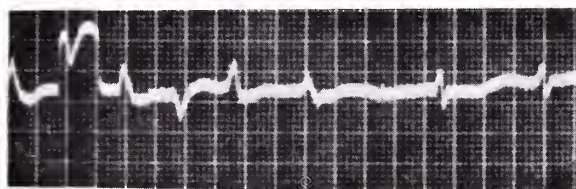


Fig. 4. Spontaneous remission from the bidirectional alternating tachycardia to a regular rhythm which resembles record in Fig. 1.

### Discussion

Fig. 1 shows a first degree A-V block. It is not likely that this could have been due to digitalis. The heart as seen on a roentgenogram was much enlarged and had an aortic contour.

In Fig. 2 the upright QRS complex is followed by a small P wave and a downward QRS complex which is slightly wider than the upward one, but in every instance the width of the negative complexes is less than 0.12 second. The interval between the upright and downward complex is longer by 0.04 second than the distance following the downward complex. The cycles are regular, and this is proven by the R-R intervals measuring the same as the S-S intervals. The P waves are seen most clearly in Leads I and II. We assume

that they are buried in the QRS complexes of Leads III and IV.

The location of the P waves suggests a nodal focus. We suspect that if the impulse that sets off the upright complex is in the lower portion of the A-V node, then the next impulse may come off from the most inferior part of the node, and depending on its location, i.e., more to the right or left side, it would then favor as the predominating ventricle the one nearest to the focus. In our case we might assume the impulse is on the left side of the lowest portion of the A-V node, thus influencing the direction of the QRS complex downward. This is of course highly speculative.

Wiggers states that there is indisputable evidence to support the contention that the vagus nerves do not directly affect the ventricles.<sup>2</sup> Fig. 3 shows the effect of right carotid sinus pressure on our patient's tachycardia. There is a period of about 9 seconds during which an almost complete cardiac arrest is interrupted by five weak ventricular contractions, none of which resembles the complexes seen in the bidirectional tachycardia. (After carotid sinus pressure was released, the patient remarked that he thought he was dying!) Following this period the record resumes a pattern of QRS complexes, low T waves, and a first degree A-V block which is quite similar to Fig. 1. The lower P waves may be explained by decreased vigor of the atria following carotid sinus pressure.<sup>2</sup> This supposition is not entirely tenable in view of the low P waves seen in Fig. 4. Here the record shows a spontaneous return to regular rhythm. The pattern is a duplicate of that which resulted from carotid sinus pressure. Fig. 5 shows further progression of the A-V block to complete A-V dissociation.

Many mechanisms have been described to explain bidirectional tachycardia.<sup>3</sup> In our case any explanation must be based on the effect of the vagus nerve. It is our opinion the probable mechanism is supraventricular in type, because carotid sinus pressure caused cessation of the tachycardia

<sup>2</sup> Wiggers, C. J.: *Physiology in Health and Disease*, Ed 4, Philadelphia, 1945, Lea & Febiger, pp. 495-496.

<sup>3</sup> a. Zimdahl, W. T.<sup>1</sup>

b. Luten, D.: *Clinical Studies of Digitalis. III. Advanced Toxic Rhythms*, Arch. Int. Med. 35:87 (Jan.) 1925.

c. Palmer, R., and White, P. D.: *Paroxysmal Tachycardia with Rhythmic Alternation in Direction of the Ventricular Complexes in the Electrocardiogram*, Am. Heart J. 3:454 (April) 1928.

d. Marvin, H. M.: *Paroxysmal Ventricular Tachycardia with Alternating Complexes due to Digitalis Intoxication*, Am. Heart J. 4:21 (Oct.) 1928.

e. Smith, W. C.: *Ventricular Tachycardia Showing Bidirectional Electrocardiograms Associated with Digitalis Therapy*, Am. Heart J. 3:723 (Aug.) 1928.

f. Schwab, E. H.: *Observation on the Etiology and Treatment of Paroxysmal Ventricular Tachycardia*, Am. Heart J. 6:404 (Feb.) 1931.

g. Strauss, M. D.: *Paroxysmal Ventricular Tachycardia*, Am. J. M. Sc. 179:337 (March) 1940.

h. Felberbaum, D.: *Paroxysmal Ventricular Tachycardia: Report of Unusual Type*, Am. J. M. Sc. 166:211 (Aug.) 1923.

i. Braun, L.<sup>4</sup>

and remission to a rhythm and mechanism resembling that seen in Fig. 1.

The possibility of an ectopic ventricular focus<sup>1</sup> explaining any part of the bidirectional tachycardia in this case is not valid because the width of the QRS complexes is less than 0.12 second, and in the last tracing (Fig. 6) the ventricular extrasystoles which interrupt the auricular fibrillation are 0.20 second wide and bear no resemblance to the QRS complexes seen in Fig. 2.

The theory of an alternating bundle-branch block has the same objections as noted above. A ventricular circus movement is not likely because the carotid sinus pressure should not directly affect ventricular activity.

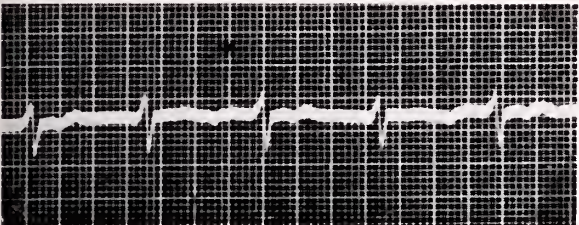


Fig. 5. Progression of A-V block to complete A-V dissociation.

After fifty-three months our patient is still alive and active. The patient reported by Braun and Wosika<sup>4</sup> died sixty-nine months after the bidirectional tachycardia was first demonstrated.<sup>5</sup> This suggests that the mere presence of a bidirectional tachycardia is not necessarily a poor prognostic sign.

<sup>1</sup> Braun, L., and Wosika, P. H.: Bidirectional Paroxysmal Tachycardia: Toxicity of Different Cardiac Glycosides, *Am. Heart J.* 29:261 (Feb.) 1945.  
<sup>5</sup> Wosika, P. H.: Personal communication.

There are variations in the electrocardiograms presented by other authors, and this further enhances the possibility of more than one explanation for bidirectional tachycardia. Until more information is available we would concur with Zimdahl and Kramer<sup>1</sup> that this type of rhythm should not be classified as a ventricular tachycardia because of the vagus nerve influence on the mechanism.

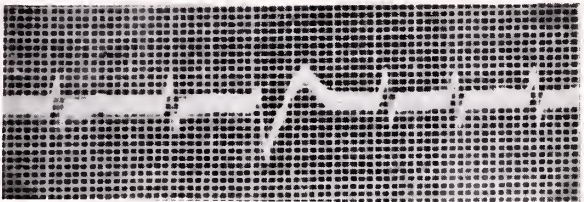


Fig. 6. Auricular fibrillation with ventricular extrasystole. There is no resemblance between this extrasystole and any of the ventricular complexes seen in Fig. 2.

Summary

A case of bidirectional tachycardia with rhythmic alternation of the QRS complexes is presented.

A suggested explanation of the mechanism on the basis of supraventricular foci is described.

Fifty-three months after the bidirectional tachycardia was first demonstrated, the patient is fairly well compensated and active.

Acknowledgment

The authors gratefully acknowledge the technical assistance of Mrs. Bruce McBride, A.B.

The Medical Group, 1135 Punchbowl Street (M.E.B.)  
Young Hotel Building (H.G.)



# International Code of Medical Ethics

*Adopted by the third General Assembly of The World Medical Association at London, England, October, 1949*

## Duties of Doctors in General

**A** DOCTOR MUST always maintain the highest standards of professional conduct.

**A** DOCTOR MUST NOT allow himself to be influenced merely by motives of profit.

**T**HE FOLLOWING PRACTICES are deemed unethical:

- a) Any self advertisement except such as is expressly authorized by the national code of medical ethics.
- b) Taking part in any plan of medical care in which the doctor does not have professional independence.
- c) To receive any money in connection with services rendered to a patient other than the acceptance of a proper professional fee, or to pay any money in the same circumstances without the knowledge of the patient.

**U**NDER NO CIRCUMSTANCES is a doctor permitted to do anything that would weaken the physical or mental resistance of a human being, except from strictly therapeutic or prophylactic indications imposed in the interest of the patient.

**A** DOCTOR IS ADVISED to use great caution in publishing discoveries. The same applies to methods of treatment whose value is not recognized by the profession.

**W**HEN A DOCTOR IS CALLED UPON to give evidence or a certificate he should only state that which he can verify.

## Duties of Doctors to the Sick--

**A** DOCTOR MUST always bear in mind the importance of preserving human life from the time of conception until death.

**A** DOCTOR OWES to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity he should summon another doctor who has the necessary ability.

**A** DOCTOR OWES to his patient absolute secrecy on all which has been confided to him or which he knows because of the confidence entrusted to him.

**A** DOCTOR MUST GIVE the necessary treatment in emergency, unless he is assured that it can and will be given by others.

## Duties of Doctors to Each Other

**A** DOCTOR OUGHT to behave to his colleagues as he would have them behave to him.

**A** DOCTOR MUST NOT entice patients from his colleagues.

**A** DOCTOR MUST OBSERVE the principles of "The Declaration of Geneva" approved by The World Medical Association.

## Declaration of Geneva

*Adopted by the General Assembly of The World Medical Association at Geneva, Switzerland, September, 1948*

**A**T THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:

**I** SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity.

**I** WILL GIVE to my teachers the respect and gratitude which is their due;

**I** WILL PRACTICE my profession with conscience and dignity;

**T**HE HEALTH OF MY PATIENT will be my first consideration;

**I** WILL RESPECT the secrets which are confided in me;

**I** WILL MAINTAIN by all means in my power, the honor and the noble traditions of the medical profession;

**M**Y COLLEAGUES will be my brothers;

**I** WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

**I** WILL MAINTAIN the utmost respect for human life, from the time of conception: even under threat, I will not use my medical knowledge contrary to the laws of humanity.

**I** MAKE THESE PROMISES solemnly, freely and upon my honor.

## SUMMARY OF THE MANAGEMENT OF THE BURN PATIENT\*

### I. Receiving Station.

- A. Estimation of surface area.
  - 1. Hospital cases—15-40% surface area burned.
  - 2. Ambulatory cases—less than 15%.
- B. Management of ambulatory cases.
  - 1. Protective occlusive absorptive non-adherent sterile dressing.
  - 2. Lung's Burn Formula—150 cc. per 1% area burned, plus 2 quarts water in 24 hours.  
NaCl 8.5 Gm.  
NaHCO<sub>3</sub> 5.5 Gm.  
Sugar 48 Gm. Water 1000 cc. Citric acid, 50%, 20 drops. Color q.s.
  - 3. Antibiotics if available—penicillin.
  - 4. Codeine, demerol, and aspirin as required.
  - 5. T.A.T. 1500 units or tetanus toxoid booster.

### II. Hospital Care—Initial Phase.

- A. Rapid survey and examination.
- B. Dressing—protective occlusive absorptive non-adherent, sterile.
  - 1. 1st layer—sterile vaseline strips—fine mesh (44) gauze.
  - 2. 2nd layer—sterile gauze squares or strips or combination rolls.
  - 3. 3rd layer—fluffs or mechanic's waste or abdominal pads (may be applied much quicker than mechanic's waste).
  - 4. 4th layer—roller (plain or elastic) bandage or Kerlix roll.
- C. Analgesics and opiates.  
Morphine or demerol—intravenous route preferable.  
Correlate with dosage received prior to admission.
- D. T.A.T. 1500 u. or tetanus toxoid booster in first 24 hours.
- E. Insertion of indwelling catheter.
- F. Application of Burn Formula.
  - 1. Accurate determination of percent of surface involvement.

- 2. In each 24 hours, give:
  - 75 cc. plasma or blood } for each
  - Blood preferable in } 1%
  - severe burns } surface
  - 75 cc. isotonic electrolyte } burned
  - a. Electrolytes to be given orally if tolerated (Lung's Burn Formula).
  - b. Normal saline intravenously if oral route not feasible.
- 2000 cc. water orally or
- 2000 cc. 5% glucose in distilled water I.V.
- 3. Half of above fluids to be given in first 8 hours.  
Half to be given in next 16 hours.
- 4. Half of above formula to be given each 24-hour period thereafter—2000 cc. water given each day to maintain urinary output.
- 5. Intake and output to be charted on special chart provided. Accurate recording essential.
- 6. If output drops below 40-50 cc. per hour for 3 consecutive hours, formula has been underestimated and should be increased.
- 7. If output exceeds 200 cc. per hour for 3 consecutive hours, patient is being overtreated and formula should be decreased.
- 8. After 48 hours wound edema is resorbed. Diuresis ensues, fluid requirements are markedly diminished, and fluid intake should be curtailed.

### III. Subsequent Phases.

- A. Dressings undisturbed for 10 days unless systemic evidence of infection.  
After 10 days change dressings.
  - 1. Saline or aqueous zephiran dressings to infected cases to prepare for grafting.
  - 2. Surgical debridement and grafting if feasible.
  - 3. Reapply same type of dressing as initially.
- B. Antibiotic therapy—penicillin 300,000 units to 600,000 units daily—streptomycin gms. ½ to 1 daily.
- C. Whole blood transfusions to combat secondary anemia.
- D. High protein, high vitamin diet.

\* From "Burn Therapy" by Rogers Lee Hill, M.D., and James W. Cherry, M.D., recently published by the Hawaii Territorial Medical Association. Copies of the monograph available at the office of the Association, at one dollar each.



## *The President's Page*

AN analysis of the diseases susceptible to either cure or prevention reveals, in the majority of cases, the astonishing fact that they may be detected early by proper attention to simple signs and symptoms. If the physician utilizes sufficient thoroughness and diligence in his diagnostic efforts, these susceptible diseases may be brought into a therapeutic range with satisfactory results. A frequently quoted popular criticism of physicians is that insufficient time is devoted to each patient. If we will remember that diligence and thoroughness will not only pay dividends in solving diagnostic mysteries that are susceptible to relatively simple therapeutics, we will go a long way toward eliminating this undesirable phase of public disapproval. Sometimes we become too engrossed in the diagnosis and therapy of diseases that are relatively immune to modern therapeutics, with a resulting disproportionate allotment of time to the simple problems that may easily and satisfactorily be solved and cured.

*Rogers Lee Hill*



# Hawaii

# MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D. Editor  
LYLE G. PHILLIPS, M.D. Editorial Director  
MRS. EDITH C. BENNETT Managing Editor  
LAURENCE M. WIIG, M.D. Notes and News Editor  
ROGERS LEE HILL, M.D. Advisory Board  
JAMES R. ENRIGHT, M.D. Advisory Board  
HASTINGS H. WALKER, M.D. Advisory Board  
PETE OKUMOTO, M.D. Associate Editor, Hawaii  
KEITH KUHLMAN, M.D. Associate Editor, Kauai  
E. T. SHIMOKAWA, M.D. Associate Editor, Maui

## [EDITORIALS]

### MODERN TREATMENT OF BURNS

Dr. Rogers Lee Hill and Dr. James Cherry have performed a signal service to us all by preparing a monograph, "Burn Therapy," outlining clearly the modern management of the burned patient. This 63-page booklet is being distributed to all physicians in Hawaii who are members of the Territorial Medical Association, and is available to others at \$1.00 a copy at the Association's office in the Mabel Smyth Building. It has attracted nation-wide recognition and has been commended by nationally known authorities on the subject of burns. A summary of it is being published in this issue of the JOURNAL, on a single page, so that it can be cut out and posted on a bulletin board or mounted otherwise for convenient use in the instruction of personnel in hospitals or aid stations.

Paramount in the modern management of burns is the maintenance of an ample, though not excessive, intake of chlorides, available base, and water. In the program advised by Drs. Hill and Cherry, this is secured by the use of a special formula devised by Mr. Lung, pharmacist of The Queen's Hospital. He has made a relatively concentrated solution of sodium chloride and sodium bicarbonate so palatable that patients can easily maintain an adequate intake of these merely by drinking the solution, with some extra water, or by eating Hawaii's most characteristic children's confection, "shaved ice," with the "Burn Formula" as the flavoring solution. The intake-output chart devised by Dr. Hill permits constant control over each patient, and makes his condition at any moment instantly apparent to the attending surgeon.

In case anyone needs to be reminded of it, *this* is medical defense against radiation warfare. Very few people with radiation injuries survive the blast; it is the *burn* casualties, in a ratio of 6 or 7 to 1, that predominate in the aid stations and hospitals. This monograph by Dr. Hill and Dr. Cherry should greatly simplify the problem of caring for large numbers of victims of—God forbid!—an atom bomb attack.

### JOIN THE AMERICAN MEDICAL ASSOCIATION NOW!

If you have not yet paid your A.M.A. membership dues of \$25.00 for 1950, you will in a few days be automatically dropped from membership. If you ever want to be reinstated, you will have to pay up this amount in addition to current annual dues. You *might* want to read a paper at the A.M.A. meeting some day—or be our delegate to the A.M.A.—or vote for a friend of yours who wanted to be delegate to the A.M.A. You'd have to be a member, not only of your County and Territorial organization, but of the A.M.A. itself, in order to do any of these things. Moreover, you owe the A.M.A. your support for its vigorous and successful defense of your interests on the national scene.

A.M.A. membership dues for 1951 have just been set, again, at \$25.00, and fellowship dues (payable on receipt of a bill) at \$5.00. Membership dues include the *Journal of the A.M.A.*; fellowship dues give you the privilege of choosing, alternatively, any of the A.M.A.'s specialty publications.

If you're excused from paying dues to your County society, you can be excused (by the County society) from paying dues to the A.M.A.; in that event you will not, of course, receive the

*Journal* except by subscription. Retired physicians are also automatically excused, as are physicians in actual training for the first five years after graduation, if they are excused from local dues.

So please, if you haven't already done so, pay your 1950 A.M.A. dues, for your own sake, and that of Hawaii's record, and in support of one of the most important and successful campaigns ever waged against state socialism. Send us your check, today!

### INTERNATIONAL CODE OF MEDICAL ETHICS

Medical ethics has long known no boundaries of time—modern doctors are governed in their relationships with patients and with one another by pretty much the same ethical code as that attributed to Hippocrates. A similar code, in simple, modern language, was agreed upon at the Third General Assembly of the World Medical Association, held in London in October of 1949. It is reproduced elsewhere in this issue of the *JOURNAL*.

A handsome printed reproduction of the Code, illuminated and engrossed in colors and ornamented by the Aesculapian staff and entwined serpent, was presented to the Medical Association by Dr. W. John Holmes, and has been placed in the office of the Association.

### HAPPY HUNDREDTH BIRTHDAY, BOARD OF HEALTH!

Hawaii's Board of Health, the oldest in the United States, celebrated its hundredth birthday on December 13, 1950. Not until 1869 was the next oldest health board, that of Massachusetts, established.

Epidemic cholera in San Francisco prompted the appointment of the original board by King Kamehameha III. It consisted of Dr. T. C. B. Rooke, Queen Emma's foster father, as chairman; Dr. George A. Lathrop, Dr. Benjamin F. Hardy, Dr. C. W. Hunter, Dr. C. Hoffman, Mr. Richard Hill Smyth, and Mr. W. Newcomb. The board was empowered to investigate reports of health nuisances, to receive reports of "malignant disease" and hospitalize any such; to enforce a port quarantine; to designate burial places; to report the incidence of communicable diseases; and to make regulations to protect the public health.

In 1851, the board spent \$10,000. In 1949-1950, their services cost the Territory \$3,700,000. What we have purchased, over the years—among other things—has been a decline from a higher

than mainland incidence to a lower than mainland incidence of almost every major communicable disease; only leprosy, plague, and endemic typhus fever are commoner here than in the mainland United States.

As Hawaii's Board of Health enters upon its second century of existence, its prospects seem bright. It has established an admirable record of accomplishments. It has won the confidence of the public in general and the medical profession in particular—the latter to such a degree that a largely medical committee, the Advisory Group to the health subcommittee of the Holdover Committee of the Legislature, recommended last fall that the indigent medical care program be transferred from the Department of Public Welfare to the Board of Health. We think this confidence is merited, and we wish them a second century as successful as their first!

### "PROBABLY BENIGN" EQUALS "POSSIBLY MALIGNANT"!

The gloomy picture still presented by the present status of the treatment of established gastric carcinoma is emphasized by Strode's report, in this issue of the *JOURNAL*, of 140 consecutive personally treated cases.

The necessity for earlier discovery and removal of these unmanageable neoplasms—for their removal at a time when they can be diagnosed only histologically—has been emphasized for some time now by surgeons at the Lahey Clinic, at the University of Michigan, in New Orleans, here in Honolulu, and elsewhere. It is finding acceptance, but too slowly.

Dr. I. S. Ravdin, in a recent issue of *Postgraduate Medicine*, comments on this slowness of reception, and wonders why it should not be more rapid. One reason why is to be found in his own words, in this selfsame article. Says Dr. Ravdin:

"It will be generally agreed that it is at times impossible for even the most skillful roentgenologist to distinguish between a benign and a malignant gastric ulcer."

Not until it is more widely realized that the most capable roentgenologist is not merely occasionally, but *always*, unable to exclude the possibility of malignancy in a roentgenologically demonstrated gastric ulcer, will the persistent deplorable tendency to "watch" gastric ulcers, and treat them medically, die out. Doctors must learn that the time-honored phrase, "Gastric ulcer, probably benign," is the exact logical equivalent of "Gastric ulcer, possibly malignant."

# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*

MISS KATHERINE NEWHALL, *Assistant Librarian*

Phone 6-5370

8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.

Monday through Friday

Closed Saturdays at noon and Sundays

Closed all day and evening on National holidays  
and at noon on Territorial holidays

## REGULATIONS

Full library privileges are extended to all regular and honorary members of the Hawaii Territorial Medical Association and the Nurses' Association of the Territory of Hawaii.

Loan privileges are extended to Associate members of the Honolulu County Medical Society.

Guest membership is extended without charge to all staff members of organizations making annual contributions to the Library, i.e. Hospital Association, Cancer Society, Tuberculosis Association, National Foundation for Infantile Paralysis, etc. Qualified research workers may apply for guest membership for one year upon payment of a fee of \$1.00. This entitles them to restricted use of the collection.

Use of books and journals in the library is extended to all military medical personnel, University students and authorized research workers.

Physicians wishing to refer patients to the Medical Library may do so by giving the patient a note stating the particular references to be used in the library, or loan privileges may be granted on the doctor's name.

Books and unbound journals circulate for a period of 10 days. A fine of five cents a day will be charged for overdue material. Material may be renewed twice, so that a loan period of 30 days in all is allowed.

Bound volumes may circulate to physicians only for a period of three days. A fine of five cents per day per issue included will be charged if volume is overdue. A minimum fine of \$25.00 will be charged for any last volume.

## RECENT ACQUISITIONS

### Anesthesiology

Leigh, M.D. *Pediatric anesthesia*. c1948.

### Atomic Medicine

Low-Beer, B. V. A. *The clinical use of radioactive isotopes*. c1950. (gift of publisher)

### Cancer

Dyer, H. M. *An index of tumor chemotherapy*. 1949. (gift of U. S. Public Health Service)

### Cardiology

Goldberger, Emanuel. *Unipolar lead electrocardiography*. 2nd ed. rev. c1949.

### Endocrinology

National Health Institute. *Abstracts of research in the field of adrenal and pituitary glands and extracts*. 1950. (gift of U. S. Public Health Service)

### First Aid

American Red Cross. *First aid textbook*. Rev. ed. c1945. Thorndike, Augustus. *Athletic injuries*. 3rd ed. rev. c1948.

### Hematology

Dameshek, William. *George R. Minot symposium on hematology*. c1949.

### Malariaology

Boyd, M. F., ed. *Malariaology*. 2v. c1949. (gift of publisher)

### Medicine, Clinical

Newburgh, L. H. *Significance of the body fluids in clinical medicine*. c1950.

### Nursing

American Red Cross. *Home nursing textbook*. c1950. (gift of Hawaii Chapter, A.R.C.)

Jensen, D. M. *History and trends of professional nursing*. 2nd ed. c1950. (gift of publisher)

### Ophthalmology

Kuhn, H. S. *Eyes and industry*. 2nd ed. c1950. (gift of publisher)

### Pharmacology

A.M.A. Council on Pharmacy and Chemistry. *New and non-official remedies*. c1950.

### Roentgenology

Ungerleider, H. E. *Roentgenology of the heart and great vessels*. 1950. (gift of the Equitable Life Assurance Society)

### Surgery

Slocum, D. B. *An atlas of amputations*. c1949. (gift of publisher)

Tarlov, I. M. *Plasma clot suture of peripheral nerves and nerve roots*. c1950. (gift of publisher)

### Therapeutics

Baruch, Simon. *An epitome of hydrotherapy*. c1920. (gift of the Baruch Foundation)

Morehouse, L. E. *Kinesiology*. c1950. (gift of publisher)

\* \* \*

The Medical Library wishes to acknowledge with special thanks the gift of the ANNALS OF MEDICAL HISTORY from Dr. Frank L. Pleadwell. This important and valuable journal began publication in 1916, and continued through three series, ceasing publication in 1942. Dr. Pleadwell also gave the Library several interesting volumes on medical history, which add greatly to our collection in this field.

\* \* \*

It might be of interest to doctors to know that the Library contributes to the UNESCO Clearing House for Publications and the U. S. Book Exchange. These organizations are trying to assist libraries in war-devastated regions to reestablish their collections. Recently we made shipments to Japan and Uganda, Africa, and have received some from Nigeria and Beirut, Lebanon.



## BOOK REVIEWS

*Cancer of the Colon and Rectum, Its Diagnosis and Treatment.* By Fred W. Rankin, B.A., M.A., M.D., LL.D., Sc.D., F.A.C.S. and A. Stephens Graham, M.D., M.S. (in Surgery), F.A.C.S. Second Edition. 427 pp. Price \$7.50. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

The second writing of this book is, in all respects, equally factual and comprehensive with the first edition, which was published in 1929, and again must be accredited as being the finest source book on the subject. I was temporarily disturbed by a statement in the preface which said "in the left colon we believe that obstructive resection is the operation of choice in the vast majority of cases." However, in the chapter on "Choice of Operations" this concept is considerably modified and tempered. I know of no other treatise on this subject which is more modern or reliable and would recommend it to any surgeon interested in having the best reference at his fingertips.

V. C. WAITE, M.D.

*Significance of the Body Fluids in Clinical Medicine.* By L. H. Newburgh, M.D., assisted by Alexander Leaf, M.D. 76 pp. with 16 figures and 6 tables. Price \$2.00. Charles C. Thomas, Springfield, Ill., 1950.

Perhaps one good doctor in a thousand has a clear understanding of the physiology of intracellular and extracellular body fluids in the healthy individual—not to mention the sick one. Yet every doctor, regardless of his special interest in any branch of medicine, meets cases almost daily which require for their proper management a clear understanding of the mechanisms of fluid exchange.

Up to now all of the writing I have seen on this subject has been so abstruse and technical that I, like most doctors, could not follow it. This small booklet is not exactly primary school reading either, but it is clear and concise and contains only solid meat. Most of the clinical problems concerned with fluid exchange are covered and explained, and where mystery still exists this is frankly admitted.

You will never understand edema, diuresis, or many other phenomena until you know what is in this book. Perhaps you already do?

H. L. ARNOLD, SR., M.D.

*Newer Concepts of Inflammation.* By Valy Menkin, M.A., M.D. 152 pp. with 81 illustrations. Price \$3.50. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

This monograph is concisely written and presents the latest concepts of the foremost authority in the field of the biochemistry of inflammation. Added features are numerous footnotes which summarize the work both verifying and contradicting that of the author. These notes are so placed that the continuity of the development of his concept in the main body of the book is not lost to the reader. Dr. Menkin has attempted to show some practical applications of his work. Above all, he brings out the problems yet to be solved in the common and very important biopathological reaction called inflammation.

W. HAROLD CIVIN, M.D.

*Freud: Dictionary of Psychoanalysis.* Edited by Nandor Fodor and Frank Gaynor. 208 pp. Price \$3.75. The Philosophical Library, Inc., 1950.

The authors have incorporated into this little volume quite a complete glossary of psychoanalytic terms. More than a mere reference book, a complete reading also gives a compact survey of the concepts of psychoanalysis.

The definitions are the result of a formidable research that encompassed all the known writings of Dr. Sigmund Freud. Freud altered many of his own formulations, and both earlier and later concepts are presented.

All who are interested in gaining further understanding of the contribution of psychoanalysis to the field of psychiatry will find this book a valuable aid.

KENNETH H. RUSCH, M.D.

*Acute Head Injury.* By Joseph P. Evans, M.D., Ph.D. 116 pp. Price \$2.25. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

This little book, publication No. 60, in the American Lectures in Surgery series is an excellent review and summary of the entire problem of acute head injury. The author has been particularly interested in the pathological physiology in these cases and summarizes the recent work in a very clear and concise manner. His inclusion of opinions divergent from his own on controversial issues is very refreshing. Sufficient illustrative cases are included to illustrate the problems and principles involved.

JOHN J. LOWREY, M.D.

*Eyes and Industry.* By Hedwig S. Kuhn, M.D. Second Edition. 378 pp. with 151 illustrations including 3 color plates. C. V. Mosby Company, St. Louis, Mo., 1950.

The second edition of Dr. Hedwig S. Kuhn's *Eyes and Industry* successfully brings under one heading most of the essential recent advances achieved in this ever growing field. This book, although written primarily for the practicing ophthalmologist, will serve as a valuable reference regarding problems of industrial ophthalmology, to safety engineers, leaders of industry, labor boards and insurance carriers.

It is unfortunate that the chapter on Radiation makes no mention of the effects of atomic radiation. The minimum visual standards recommended by the author for tractor and truck drivers and machine operators seem far too liberal in comparison with similar standards accepted in the Territory of Hawaii.

Regarding muscle balance for various occupations, the author merely states that this function must be normal. According to Prangen of the Mayo Clinic, "any state of extra-ocular muscle balance, which causes a person no discomfort, is normal for that individual." Thus, the industrial ophthalmologist is left to establish his own standards for each case, and may find himself questioning the value and significance attached to routine examination of phorias in industry.

The book is well illustrated, containing over 150 photographs and charts.

WILLIAM JOHN HOLMES, M.D.

*The Clinical Use of Radioactive Isotopes.* By Bertram V. A. Low-Beer, M.D. 436 pp., 105 illustrations. Price \$9.50. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

The book is divided into two parts. The first deals entirely with radiation physics. Most of this can be found in any of the standard radiation physics textbooks. There are several chapters devoted to the new problems incident to radioactive isotopes. This part would not be of general interest to the average practitioner.

Part two treats with the clinical application of the various radioisotopes. It briefly and concisely gives the indications, manner of use and results that may be expected. The chief value of the book is the accumulation of much of the voluminous data from recent literature under one cover and presenting it in a form that is readily digestible.

PHILIP S. ARTHUR, M.D.

*Bone and Joint Diseases.* By J. Vernon Luck, M.S., M.D., F.A.C.S., F.I.C.S. 614 pp. Price \$16.50. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

This is a new textbook of pathology of bones and joints emphasizing the correlation of pathological anatomy with the associated X-ray and clinical findings. It is profusely illustrated with photographs, many in colors, showing the gross pathology, X-ray appearance and the microscopic detail. In many instances where pathologic changes are reversible, the physiological repair is presented serially with an excellent, orderly, simple, accompanying descriptive text. Every chapter opens with a detailed outline giving serially, in decreasing order of incidence, the most frequently expected disorders. Completing each chapter is an excellent collection of references on each type of pathology, permitting the reader or an investigator to quickly reach original or more detailed information if he wishes. There are no footnotes.

This text on applied physiology in pathology is welcome proof of a growing awareness that even in controversial subjects there is much that is understood. For example, no one can help but delight in such pictures as appear on page 9 of this text. This newer knowledge will go far to make more interesting a phase of the reader's interpretation of X-rays and the care of his patients.

JOHN W. COOPER, M.D.

*Basic Principles of Clinical Electrocardiography.* By Hans H. Hecht, M.D. 88 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

This short booklet on the basic principles of clinical electrocardiography is an attempt to briefly explain the value of the fairly recently introduced chest and unipolar limb leads. On page 35, it is stated: "The unipolar limb leads bridge the gap that exists in the physicians' mind between the system of precordial leads relatively recently introduced in clinical electrocardiography and the classical procedure by which electrocardiograms have obtained for over 50 years." It might be stated that this book fairly well does the same.

For the beginner, the advantages of this book are two: first, it is small; and secondly, the normal and variations from the normal due to position of the heart are stressed. This certainly would be a good book with which to begin the study of the unipolar semi-direct leads from the chest. For a person who wishes to study abnormalities in the electrocardiogram due to heart disease, however, one must look further.

ALFRED S. HARTWELL, M.D.

*An Atlas of Amputations.* By Donald B. Slocum, M.D., M.S. 562 pp., with 564 illustrations. Price, \$20.00. C. V. Mosby Co., St. Louis, Missouri, 1949.

Contradicting its title, this book is a quite comprehensive study of the entire subject of amputations.

The author had sound background for this writing in his position as Chief of the Amputation section of Walter Reed General Hospital, Washington, D. C., during World War II. The volume's especial strong point is the section on convalescence, including stump hygiene, etc.

Part I concerns indications and objectives under a heading of "orientation." Part II is a detailed description of surgical preparation and wound healing. One notes a lack of details regarding refrigeration technic, but this is not a great loss, since application of such is very limited.

Part III is the detailed description and illustration of amputations. The plates are excellent and the large format further enhances them.

Part IV is a most valuable section on convalescence, body mechanics, and walking, and some mention is made of the suction socket.

The text is interesting reading, and the book is a real contribution as a reference for any surgeon called upon to do an amputation.

T. ALAN CASEY, M.D.

*Surgery of the Eye: Injuries.* By Alston Callahan, B.A., M.S. (Ophth.), M.D., F.A.C.S. 217 pp. Price \$11.50. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

This book brings the important subject of eye injuries up-to-date. In this clearly and beautifully illustrated volume, the author condensed his vast experience of the early and late management of trauma to the globe and the orbital adnexa.

Through the medium of his well demonstrated case records, he leaves little doubt in the reader's mind regarding the method of approach he uses for the repair of individual deformity. To the busy ophthalmologists, the chapters dealing with adnexal injuries will have special appeal. Here, detailed, step-by-step procedures are given for the repair of canthal deformities and reconstructions of the eye brows, lids, cilia, socket, and orbit.

Following the first World War, Imre and Blaskovics laid down the fundamental principles of plastic surgery about the eye lids and orbits. Callahan's atlas replaces these old masters by providing improved and modern versions for the treatment of these serious and deforming lesions.

WILLIAM JOHN HOLMES, M.D.

*Plasma Clot Suture of Peripheral Nerves and Nerve Roots.* By I. M. Tarlov, M.D. 116 pp. Price \$5.50. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

This little book clearly and concisely describes the history, development and method of plasma clot suture. The author has had much to do with this development and speaks with authority on the subject. Any surgeon doing general or traumatic work may occasionally be called upon to do a nerve suture. While he may not choose to use the plasma clot technic, still the principles laid down in this book in striving for a perfect suture are valid and well worth following. The excellent results obtained in favorable patients in the last war using fine tantalum wire by those familiar with the technics will probably not make many change in their methods except in certain instances.

JOHN J. LOWREY, M.D.



*History and Trends of Professional Nursing.* By Deborah MacLurg Jensen, R.N., B.S., M.A. Second Edition. 365 pp. Price \$3.25. C. V. Mosby Company, St. Louis, Missouri, 1950.

In revising this text, the author has brought it up to date with information about some of the latest organizational and professional developments in nursing service and nursing information.

The name has been changed from *History of Nursing* to *History and Trends of Professional Nursing*. The new title more nearly describes the scope of the book since it does not cover the whole field of nursing history but traces the trends which have influenced the development of nursing as a profession. Mrs. Jensen approaches the subject from a sociological point of view.

The book is divided into four parts, of which the first three trace the development of nursing into three periods, namely: from the earliest times until the latter part of the 18th century; from the latter part of the 18th century until the establishment of the first modern school for nurses at St. Thomas' Hospital, England in 1860; and from 1860 until the present.

Part 4 describes the development of professional nursing in other countries. There are study questions and reference lists at the ends of the units. Instructors will find this book valuable as a reference text for history of nursing.

ROSIE K. CHANG, R.N.

*Kinesiology.* By Laurence E. Morehouse, Ph.D., and John M. Cooper, Ed.D. 435 pp. Price \$4.50. The C. V. Mosby Co., St. Louis, Mo., 1950.

This book, written by two non-medical doctors, one of philosophy and one of education, is planned for teachers of physical education but is far too advanced for the student of that subject. It is definitely not designed for the physician, but it does discuss, in a physio-anatomical manner, muscle action, which justifies its name, although much of the subject matter is anatomy, physiology and mechanics. The last chapter only is pure kinesiology and could be very effectively expanded to make the book more useful and suited to its title.

This publication is designed evidently for students who do not have ready access to the dissecting room or even anatomical textbooks, and the authors, although they themselves apparently have not had dissecting room experience, have effectively combined muscle physiology with anatomy. A few errors, such as considering the fibula as a "weight supporting strut" (page 91) are somewhat misleading but are not frequent enough to seriously detract from the purpose for which the anatomical discussions are intended.

The book is well illustrated and well indexed and the full table of contents divides the text almost into paragraphs, adding much to its value as a reference book for the physical educationalist. Many references are given but no specific documentations of statements such as pages are cited.

The chief advantages of this treatise on the science of muscle action are the illustrations of muscle action and physics. The chief fault of the book is the lack of adequate concrete suggestions for the physical improvement of "kinesiologically defects," but it must be remembered again that this publication is not intended for the physician but for the instructor in physical education. This is a book for a medical library but not for a physician's bookshelf.

J. WARREN WHITE, M.D.

*Malariaology.* By Sixty-five Contributors. Edited by Mark F. Boyd. Volumes I and II. Pp. 1 through 1,643; figs. 1 through 436. Price \$35.00 set. W. B. Saunders Company, Philadelphia and London, 1949.

The subtitle "A Comprehensive Survey of All Aspects of This Group of Diseases from a Global Standpoint" well describes this pair of volumes. As such, much of it will be of small interest to practicing physicians, who would do well to skip over or omit entirely the first volume, and a majority the second volume as well. However, Chapters 40-49, dealing with clinical malaria and its treatment, are recommended to any doctor called on to treat malaria, and are interesting as well as comprehensive and authoritative. Chapter 45 on Blackwater fever comes as close to explaining this obscure phenomenon as anything I have read.

F. D. NANCE, M.D.

*Public Health Nursing Practice.* By Ruth B. Freeman, R.N., B.S., M.A. 337 pp. W. B. Saunders Company, Philadelphia & London, 1950.

Miss Freeman presents public health nursing as an integral part of health services in the community, dynamically related to current social and technical developments. Her book deals with the methods and procedures used by the public health nurse in her daily work as a member of the health team.

In doing this she has brought together many aspects of public health nursing and made clear statements as to current thinking and practice in regard to them.

Her section on writing an annual report contains nine practical suggestions. In her chapter "Securing Acting" she points out four major reasons for families' failure to follow through on health plans, and discusses factors which may be operating in each and ways of dealing with them. Any nurse would be interested in her presentation of leadership competence and how to "substitute leadership for advising."

Miss Freeman says that she selected her material primarily to meet the needs of graduate and undergraduate university students. The book will become increasingly valuable to the young nurse, however, as she begins her community work and encounters the situations with which Miss Freeman deals. Older nurses will find stimulation, or reassurance that their thinking is in accord with current practice.

In presenting such a large subject in a practical and concrete way, Miss Freeman inevitably runs the risk of over simplification, as in her pages on emotional blocks. She has, however, supplemented her material with excellent bibliographies at the end of each chapter.

LAURA A. DRAPER, R.N.

## Also Received

*Medical Clinics of North America.* Mayo Clinic Number. Psychiatry and the General Practitioner. 939-1251 pp. \$18.00 per clinic year, cloth binding; \$15.00 per clinic year, paper binding. W. B. Saunders Company, Philadelphia and London, 1950.

*Surgical Clinics of North America.* Mayo Clinic Number. Abdominal Surgery. 961-1249 pp. Price \$18.00 per clinic year, cloth binding; \$15.00 per clinic year, paper binding. W. B. Saunders Company, Philadelphia and London, 1950.

*Researches in Binocular Vision.* By Kenneth N. Ogle, Ph.D. 345 pp. with 182 figures and 26 tables. Price \$7.50. W. B. Saunders Co., Philadelphia and London, 1950.

*Medical Clinics of North America.* November 1950 Number. Philadelphia issue. Pp. 1,587 to 1,910. Three-Year Cumulative Index (1948, 1949, 1950). Price \$18.00 per clinic year, cloth binding; \$15.00 per clinic year, paper binding. W. B. Saunders Co., Philadelphia and London, 1950.

*Surgical Clinics of North America.* Philadelphia Number. Clinical Surgery. Pp. 1,249-1,544. Price \$18.00 per clinic year, cloth binding; \$15.00 per clinic year, paper binding. W. B. Saunders Co., Philadelphia and London, 1950.



# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## COUNCIL MEETING

Friday, December 15, 1950 at 7:30 p.m.  
Mabel Smyth Building

Dr. Hill presided. Drs. Tilden, F. J. Pinkerton, Rothwell, McArthur (Maui), Wade (Kauai), Orenstein (Hawaii), R. K. C. Lee, and also Drs. Hartwell, R. B. Faus and Kawasaki, were present.

*A.M.A. Meeting:* Dr. Hartwell reported on the highlights of the A.M.A. convention in Cleveland which he had just attended as Delegate.

1. A half million dollars was appropriated for private medical schools from the national education campaign fund. The next day it was announced an additional ten thousand dollars had been contributed from private donations.
2. Implementation of the Hess report was discussed. Its purpose is to prevent exploitation of salaried pathologists, radiologists and anesthesiologists in hospitals.
3. Civilian defense plans stressed defense by dispersal. Adequate supplies of plasma should be scattered about. Close correlation of plans between towns.
4. "Burn Therapy," the new manual by Dr. Hill and Dr. Cherry, was brought to the attention of the leaders of the A.M.A., the Army, the Navy, etc. It evoked considerable interest and many favorable comments.

Dr. Kawasaki reported that he had attended a special meeting of the Council on Medical Emergency Service held during the Cleveland session. By July 1, 1951, 1729 doctors will be called into service. This quota will be broken down by corps areas. The Council felt Hawaii's defense plans were far advanced and asked for a written account of what is being done here. Dr. Faus had prepared such a statement, which he read to the Council.

*A.M.A. Dues:* It was reported to the Council that Kauai has paid 100 per cent of the \$25 A.M.A. dues for 1950, Hawaii has a very good record, Maui has done fairly well, but Honolulu has only about 66 per cent paid A.M.A. members. Dr. Orenstein described the effective method he used in Hawaii, making out \$25 checks and presenting them to the individual members for signature. Serious concern was expressed over the poor Territorial record. Dr. Hill will discuss the matter with Dr. Yee, president of the Honolulu Society.

*Resignation:* The Council received a written resignation from Dr. Orenstein as alternate delegate to the A.M.A.

**ACTION:** On motion of Dr. Pinkerton, seconded by Dr. Tilden, the resignation of Dr. Orenstein was accepted with regret.

*A.M.A. Convention Expenses:* Mrs. Bennett reported that United Air Lines had given us a free round trip to

San Francisco for her and half a trip for Dr. Orenstein. Although \$2,320 had been budgeted for the year, only \$1,761 was spent. The budget for Dr. Hartwell's expenses at the San Francisco meeting had been \$200 but he turned in an account of \$237 which he spent. He also asked for \$25 to contribute toward a dinner given by the delegates of small states and territories at the Cleveland meeting. In view of the savings on plane fares from United, this additional amount of \$62 had been advanced to Dr. Hartwell.

**ACTION:** On motion of Dr. McArthur, seconded by Dr. Orenstein, the Council approved the payment of \$62 to Dr. Hartwell for additional A.M.A. expense.

*Report by Dr. Faus:* Dr. Faus reported that about 20 doctors in Hawaii had had physical examinations by Selective Service. About 7 hospital residents have been deferred for 6 months with the possibility of a second 6 months to complete their residency. Dr. Faus, Dr. Wilbar and Dr. Dave have been appointed an advisory committee to Selective Service, with advisory committees in each county. There has been good cooperation between the committees and Selective Service. County committees will consider deferment requests.

Dr. Faus reported that raising dues and cutting obstetric benefits has put H.M.S.A. in a good cash situation, although utilization has been high. The status of the physicians' reserve will be determined by the auditors in February.

In civilian defense, Dr. Faus reported that Dr. Wilbar has been appointed head of the health services for the Territory with Dr. Mossman as head of the emergency medical service for the county. Inventories of supplies and personnel have been made. The Board of Supervisors has appropriated \$50,000 to be used for the purchase of certain critical items necessary for treating patients. Under Dr. Dickson, the aid station units are now being organized. Aid station training will be by physicians. First aid training will be by the Red Cross. It is the responsibility of the community to get the volunteers out for training. Then the doctors will be furnished to train them.

*Disaster Appropriation:* The need for a large sum of money to provide adequate medical supplies and equipment for disaster was discussed.

**ACTION:** On motion of Dr. Orenstein, seconded by Dr. Pinkerton, the Council unanimously agreed that the Hawaii Territorial Medical Association should support to the utmost the securing of necessary preliminary funds at this time to carry out plans for the emergency care of casualties, and that a resolution to this effect should be prepared and submitted to the proper authorities.

*Burn Therapy:* The Council was informed that Dr. Hill and Dr. Cherry had prepared a manual entitled "Burn Therapy," with the cooperation of many others.

The book was published in printed form and complimentary copies were sent to all members of the Territorial Medical Association and to various key individuals in the A.M.A., the Army, Navy, etc. The total expenditure to date has been about \$1300. All bills were paid from the Preparedness Committee fund and not from Hawaii Territorial Medical Association funds. The extra copies of "Burn Therapy" are now being sold at \$1 a copy and the amounts received will be returned to the Preparedness Committee's savings account. The Council thanked Dr. Hill for his work.

*Christmas Gifts:* Since the Honolulu Society is giving generous gifts to the Mabel Smyth janitor and maid, it was decided not to duplicate these.

**ACTION:** On motion by Dr. Pinkerton, seconded by Dr. Orenstein, the Council voted to give \$5 to the postman, \$25 to Shizuko Odo and \$50 to Mrs. Bennett for Christmas.

*Hawaiian Directory:* The Hawaiian Directory Company had asked for approval of placing "professional cards" in the medical section of a proposed new Hawaiian directory.

**ACTION:** On motion of Dr. Pinkerton, seconded by Dr. Orenstein, the Council disapproved of professional cards by doctors in the proposed Hawaiian directory.

*Postgraduate:* The Tuberculosis Association would like to bring an outstanding chest specialist to Hawaii

in the spring to address the doctors, the nurses, and other groups. The expenses would be borne entirely by the Tuberculosis Association, but they would like to have the Territorial Medical Association as a joint sponsor of a series of about three lectures. Since the Honolulu Society has already completed plans for bringing an obstetrician and a gynecologist, this matter was turned over to Dr. Waite, postgraduate chairman of the Territorial Medical Association, who is working on the plans with Dr. Walker and the Tuberculosis Association.

**ACTION:** On motion of Dr. Pinkerton, seconded by Dr. Orenstein, the Council approved of the Territorial Medical Association supporting jointly a series of postgraduate lectures by a chest expert to be brought to Hawaii by the Tuberculosis Association.

*Emergency Calls:* Dr. Hill brought up the subject of emergency calls for doctors. He reported that there had been quite a number of recent cases in which patients had had considerable difficulty in finding a doctor for an emergency house call. Dr. Kawasaki said that he was a member of a three man committee now formulating plans for emergency medical calls to be submitted to the Honolulu Society for consideration. The doctors from Hawaii, Maui and Kauai reported that they had no such problem in their counties.

There being no further business, the meeting was adjourned.

I. L. TILDEN, M.D.  
Secretary

## COUNTY SOCIETY REPORTS

### HAWAII COUNTY MEDICAL SOCIETY

The 301st regular meeting of the Society was called to order by the president, **Dr. Leo Bernstein**, at 7:50 p.m., October 26, 1950, at the staff room of the Hilo Memorial Hospital. **Drs. Fred Gilbert, H. Higa** and **Richard Neil** were present as guests.

**Dr. Fred I. Gilbert, Jr.**, an instructor in Internal Medicine at Stanford University School of Medicine, on leave of absence at present, gave an informative up-to-date talk on cortisone, including his personal experiences with the new drug. He closed his talk with the thought that cortisone is used in the experimental stages yet, that it should be used as a last resort, and that the financial status of the patient should be considered before initiating treatment with this drug.

Letter dated September 29, 1950 from **Dr. Rogers Lee Hill** to **Dr. Leo Bernstein**, on the matter of medical examination of Territorial and County civil service employees was read. The attached communication dated July 31, 1950 from Representative Herbert K. H. Lee to Representative Thomas T. Sakakihara of the Holdover Committee of 1949 was also read. This matter was thrashed out at a meeting of the Legislative Committee

on October 24, 1950. Its recommendations were read at this time as follows: The Legislative Committee recommends (a) the pre-employment medical examination of civil service personnel by private physicians continue as at present, (b) the approval of periodic medical examinations of permanent employees through education and not by compulsion at stated intervals. The results of the previously mailed questionnaire were also read out to the members present.

**Dr. Yuen** moved, seconded by **Dr. Miyamoto**, that this society approve the medical examination of all civil service employees by private physicians and that these examinations be paid by the employees. Motion carried.

The Proposed Law for Territorial Legislature 1951 was read. This proposed law is intended to amend the Public Health Laws in relation to the reporting of cancer and other malignant tumors. The Legislative Committee recommends (a) Cancer and other malignant tumors be made reportable but without the person's name. Initials may be substituted. (b) One complete report by the physician, including comprehensive answers to leading questions, to the Territorial Health Department or to the appropriate county health officer. (c) Reports should be in the Territorial Health Department or to



the appropriate county health officer within two (2) weeks after diagnosis is made or obtained by the attending physician.

**Dr. Orenstein** moved that the Legislative Committee report be accepted. This motion was seconded by **Dr. Yuen** and duly carried.

Letters of thanks from the Woman's Auxiliary to the Hawaii Territorial Medical Association and the Woman's Auxiliary to the Hawaii County Medical Society for the donation of \$250.00 toward flowers that were sent to the A.M.A. Convention in San Francisco were acknowledged.

1. Oahu Health Council. The action taken at the August 18, 1950 meeting of this society to join the Oahu Health Council if and when their Constitution and By-laws permit it was deferred. This deferment came about when **Dr. Hiscock** recommended that the Island of Hawaii have its own Health Council and that we affiliate with the local council instead of with the Oahu Health Council.

2. Free Choice of Physicians. The majority of the Legislative Committee, to which this matter was referred for investigation and recommendation, was in favor of free choice of physician by the employees under the Workmen's Compensation Act. Much discussion followed.

**Dr. Yuen** moved, seconded by **Dr. Mizuire**, that the society accept the recommendations of the Legislative Committee. Carried by a 12 to 3 vote.

3. Increase in Dues. An amendment to the Constitution and By-laws to increase the dues \$10.00 from \$40.00 to \$50.00 had been initiated by motion from the floor at the regular meeting of this society on August 10, 1950. A copy of this amendment had been mailed to each member at least 15 days prior to this meeting.

**Dr. Orenstein** moved, seconded by **Dr. Miyamoto**, that we approve the amendment. Carried by a secret vote of 14 to 1.

Membership Application. **Dr. Fred I. Gilbert, Jr., Dr. Hoei Higa** and **Dr. Richard Neil** were unanimously elected into the society by secret vote.

Annual Meeting. **Dr. Mizuire** stressed that, heretofore, the annual meeting was a dinner meeting where the president played host to the members and paid for the entire dinner. He pointed out that this was all right formerly when the membership was small, but now it has grown too large and the cost to the president will be too great.

**Dr. Crawford** moved that the annual meeting be made a dutch treat affair. **Dr. Kasamoto** seconded it.

**Dr. Orenstein** amended the motion by moving that each member of the society be assessed for the annual meeting whether he is present or not. **Dr. Kasamoto** seconded it. The motion as amended passed unanimously.

The 302nd regular meeting of the Hawaii County Medical Society was called to order by the president, **Dr. Leo Bernstein**, at 7:30 p.m., November 30, 1950, at the staff room of the Hilo Memorial Hospital.

**Dr. John Milford**, formerly a member of the Physiology Department staff of the University of Washington Medical School, gave a talk on the "Viruses as an Etiologic Agent of Cancer." This talk was based on his experiments with virus on chick embryo.

PETE T. OKUMOTO, M.D.  
Secretary

## HONOLULU COUNTY MEDICAL SOCIETY

The Society met Friday, November 3, 1950 at 7:30 p.m. in the Mabel Smyth Auditorium. **Dr. Devereux**, Vice-President, presided; about 153 members and guests were present.

**Dr. Durant** reported that the Chamber of Commerce had been very helpful in the addressing and mailing of public service material. Opinions of doctors are highly respected by businessmen and more doctors should join and support and serve on committees of the Chamber.

A letter commending **Dr. Samuel Yee** for services rendered as Medical Advisor of Selective Service, Local Board No. 1, was received and read to the membership.

Together with the last Board of Governors Bulletin was sent a letter signed by **Dr. Arnold, Jr.**, as chairman of the Legislative Committee, regarding a proposed amendment to the Pharmacy Act. According to the present law, doctors may not delegate to an employee the job of dispensing medicines. A meeting with 3 representatives of the Medical Society and 3 representatives of the Pharmacy Association resulted in a compromise in which doctors may delegate to a registered nurse or registered pharmacist the job of dispensing medicines. The matter was discussed at some length. Approximately one-fourth of the members present indicated that they regularly dispensed medicine directly to their patients through the services of an employee other than a registered nurse or registered pharmacist. It was brought out in the discussion that the majority of these doctors felt that their office employees, who in most instances are practical nurses, were perfectly competent to assume responsibility for the type of dispensing they were required to do and that these same doctors felt it would be economically impossible for them to comply with the suggested compromise amendment by employing a registered nurse in their stead. It was also brought out in the discussion that physicians supplying their own patients with medication were fully responsible for the proper conduct of that procedure and need not be restricted by law as to the way in which they do it. **Dr. Arnold, Jr.**, moved that the Medical Society support the amendment as originally proposed by the Advisory Group. Motion was seconded and carried unanimously.

The following ultra-scientific program was presented:

1. What's to Come in Medicine—Dr. Wm. M. Walsh
2. The Determination of Sex in Private Practice—Dr. Paul Gebauer (slides)
3. Some Observations on Mainland Veterinary Clinics—Dr. J. E. Strode
4. When Psychiatric Treatment Fails—Dr. David Katsuki

Following the meeting, refreshments were served in the lanai.

The regular December membership meeting of the Honolulu County Medical Society was held on Friday, December 1, 1950, at 7:30 p.m. in the Mabel Smyth Auditorium. **Dr. Samuel Yee** presided; about 71 members and guests were present.

The president reported that the Board of Governors at its last meeting approved the tentative plan of the Cancer Society to go ahead with the proposal of giving free diagnostic services to those patients who are not medically indigent yet not able to pay for expensive diagnostic tests. This program will be underwritten by the Cancer Society in cooperation with hospitals in town. Details will be worked out and will be announced to the membership at a later date.

**Dr. George F. Straub** presented the following resolution:



## RESOLUTION

WHEREAS, Dr. Guy Champion Milnor has been an outstanding practitioner of medicine in general and obstetrics and gynecology in particular, in Honolulu, for the past 36 years; and has contributed greatly to the elevation of the standards of medical practice here during that period of time; and

WHEREAS, he was a member of the Hawaii Medical Society, and has been President of both the Honolulu County Medical Society and the Hawaii Territorial Medical Association; now therefore

BE IT RESOLVED, that the members of the Honolulu County Medical Society do hereby express their deeply felt sense of loss, both personal and professional, at his recent and untimely death; and be it further

RESOLVED, that a copy of this resolution, signed by the President and Secretary of the Society, be sent to Mrs. Milnor, spread upon the minutes of this Society, and published in the Hawaii Medical Journal.

Given under our hand this first day of December, 1950.

Samuel L. Yee, M.D., President  
Wm. M. Walsh, M.D., Secretary

Dr. Devereux moved that the resolution be adopted and a copy presented to Mrs. Milnor. Motion was seconded by Dr. Berk and unanimously passed by a standing vote.

"Dissecting Aneurysms of the Aorta" was discussed by Dr. C. A. Domzalski, and "Late Spontaneous Healing of Fracture Deformities" was the topic presented by Dr. J. Warren White.

Dr. Fronk was then called upon to give a short resume of his recent trip to the Mainland and Mexico.

Meeting adjourned at 9:30 p.m., following which refreshments were served in the lanai.

WM. M. WALSH, M.D.  
Secretary

## KAUAI COUNTY MEDICAL SOCIETY

The regular meeting of the Kauai County Medical society was called to order by Dr. Goodhue at 7:30 P.M.

Wednesday, October 11, 1950, at the Wilcox Memorial Hospital Library.

The question of the advisability of providing for medical examinations of all new civil service employees and periodical examination of all permanent employees was brought up and subjected to considerable discussion. It is the unanimous opinion of the Kauai County Medical Society that such a program should be on a fee for service basis with a free choice of physicians to the patients. This was moved, seconded, and carried.

The meeting was adjourned at 8:40 P.M.

P. M. COCKETT, M.D.  
Acting Secretary

## MAUI COUNTY MEDICAL SOCIETY

A regular dinner meeting of the Maui County Medical Society was held at the Maui Grand Hotel on December 19, 1950 at 6:15 P.M. with Dr. Cole presiding.

Dr. Robert Faus spoke on the federal defense set-up in our territorial disaster plan and the part the outside islands could contribute to Honolulu in case the city was stricken by atomic bomb. He also gave an interesting report on HMSA experience for Maui. He concluded his talk on the Selective Service System as it applies to the medical profession.

Mr. Lane, deputy disaster director for Maui County, reported on our civilian defense set-up, discussing particularly the setting up of an adequate disaster warning system.

Dr. Cole appointed a committee for selection of a resident pathologist composed of Dr. St. Sure, Jr. (Chairman), Drs. Tompkins, Toney and A. Y. Wong.

Dr. Jesse I. Knox, Jr., was unanimously elected a regular member of the Society.

A letter dated November 4, 1950 from Dr. Lee of the Board of Health to Dr. Cole relative to the importance of the formation of a Maui Health Council was read. The members present felt that the formation of a health council should be a project of the Maui Chamber of Commerce with the Society participating in an advisory capacity. No action.

EDWARD T. SHIMOKAWA, M.D.  
Secretary

# NOTES AND NEWS

## PERSONALS

**Dr. Rogers Lee Hill**, of Honolulu, was certified in November by the American Board of Thoracic Surgery as a member of the Founders' Group.

The St. Francis Hospital, of Honolulu, has added to its resident staff **Dr. Frank E. Glazer**, of Milwaukee, Wisconsin. Dr. Glazer was a graduate of the University of Wisconsin in June 1950. He served the first portion of his internship at the University of Iowa Hospital, Iowa City, Iowa. This hospital has also added **Dr. A. M. Toyota**, a native of Kauai, who was educated at the Toho Medical College, Japan. She has completed one year of internship at the Kuakini Hospital, Honolulu. Dr. Toyota will serve a mixed residency. **Dr. Edmund C. K. Lum**, also of Honolulu, is a resident at the St. Francis Hospital, having served his internship there several years ago and recently has completed post-graduate studies at the St. Francis Hospital, Evanston, Illinois, where he served as a surgical resident. He is a graduate of Northwestern University Medical College, in 1948.

The Kuakini Hospital, of Honolulu, has added to their resident staff **Dr. Naoya Miura**, a native of Kobe, Japan. He is a graduate of Nippon Medical College. Dr. Miura interned at the Hyogo Prefectural Medical College Hospital, in 1948 and 1949.

The Children's Hospital, of Honolulu, has added **Dr. Stephen Z. M. Voong**, a native of Shanghai, China. He is a graduate of St. John University, Shanghai, in 1940. He has served a residency in pediatrics at the St. Vincent Hospital, New York City, prior to coming to the Children's Hospital.

**Dr. Y. Ueyehara**, of Honolulu, is the generous donor of two new electroshock machines, which he has sent to Okinawa for use there on civilian and military populations. Arrangements were made by **Dr. R. D. Kepner**, of Honolulu with **Dr. Rolf von Scorebrand** (who was formerly a practicing physician here in Hawaii at the Kalaupapa Settlement), Director of Public Health and Welfare, Military Government, Ryukuan Command, for his acceptance of these gifts on behalf of the entire Ryukuan community. Dr. Scorebrand agreed to see that the best possible use was made of these machines and stated that there was available on Okinawa psychiatric personnel to operate such equipment. Dr. Ueyehara is to be strongly commended for his great generosity to the people of Okinawa.

The Honolulu dermatologists have been quite active in recent months as evidenced by the following news items: **Dr. Harold M. Johnson** and **Dr. Harry Arnold, Jr.**, attended the meeting of the American Academy of Dermatology, in Chicago, in December at which time they both participated and delivered papers. Dr. Arnold spoke on "Classification and Diagnosis of Leprosy." He also participated in a round table discussion on bacteriology of the skin. Dr. Johnson delivered a paper on the "Clinical Aspects of Leprosy and Its Treatment." Also attending the Academy meeting was **Dr. Cyrus Loo**, of Honolulu, who was honored along with **Dr. Samuel Allison**, of Honolulu, by being certified by the American

Board of Dermatology. Our congratulations are extended to all concerned.

**Dr. Edwin Young**, the son of Mr. and Mrs. Ah Ki Young, of Honolulu, has opened his office in the National Building. Dr. Young is specializing in eye, ear, nose and throat and oral surgery. He holds the degrees of D.D.S. and M.D. He took graduate training in his specialty at the Mountinside Hospital, New Jersey, and Long Island College of Medicine, in New York, as well as at Northwestern University, where he received his degrees. Dr. Young is an alumnus of St. Louis College, of Honolulu, and the University of Dayton, in Dayton, Ohio. He served a residency at the St. Francis Hospital, Honolulu, prior to returning for specialization.

**Capt. William C. Hedberg**, an associate member of the Honolulu County Medical Society, who is stationed in Korea, was recently awarded the Silver Star by Lt. Col. John L. Throckmorton, Commanding Officer of the 5th Infantry Regiment, in Korea. The award was made to Capt. Hedberg for rescuing a severely wounded American soldier, who had crawled under a burning ammunition trap to escape further enemy fire. Before being sent to Korea Capt. Hedberg was assigned to the Tripler Army Hospital, Honolulu. Mrs. Hedberg resides at 188 Dewey Way, Honolulu.

Two good examples in the local medical profession of excellent public relations have recently been demonstrated when two of our members were elected to office in community organizations. **Dr. Lyle G. Phillips** was elected president of Imua, a very active anti-Communist organization in Honolulu. Also making his contribution to community enterprises is **Dr. Harry Arnold, Jr.**, who was elected president of the Kahala Community Association.

Also active in community affairs in recent months has been **Dr. Theodore Tomita**, who served as chairman of a committee sponsoring a fund raising campaign for scholarships for the island nurses. This was an activity of the Honolulu Junior Chamber of Commerce in which Dr. Tomita is active. Also doing his share was **Dr. Richard W. You**, who is chairman of the Public Health Committee of the Honolulu Junior Chamber of Commerce and has been active in securing blood donors for the Honolulu Blood Bank. Any physician or nurse who has not yet donated a pint of blood is still welcome to do so, according to Dr. You.

**Dr. William H. Stevens**, Honolulu psychiatrist, and Mrs. Stevens have returned from a recent mainland visit, during which time they experienced some of the floods in the Pacific Coast region. (It is not essential to go so far for this purpose. Ed.)

**Dr. and Mrs. Theodore Tomita** are the proud parents of their first son, Stilson Noriyoshi, making a total of four children with their three daughters.

**Dr. Walter B. Quisenberry** recently became Hawaii's third diplomate (and the first to be certified by examination) of the American Board of Preventive Medicine and Public Health. **Drs. Charles Wilbar** and **Richard K. C. Lee** had previously been certified as members of the Founders' Group. During his mainland trip, Dr. Quisenberry served with **Dr. Pauline G. Stitt** as delegate

to the mid-century decennial White House Conference on Children and Youth. Dr. Quisenberry also visited Dr. George Papanicolaou, Drs. Charles Warren and Olive Gates in Boston, the American Cancer Society headquarters in New York, and the National Cancer Institute in Washington, D. C. He reports great interest in our studies of racial incidence of cancer, and that there was general approval of the way in which our Hawaii Cancer Society has conducted its cytologic diagnostic service.

## Hawaii

### More Woe

**Dr. and Mrs. Richard Yamanoha** welcomed a daughter, Patricia Sei, on October 24, 1950. Patricia has a brother.

**Dr. and Mrs. Robert Miyamoto** increased their clan on November 6, 1950 when a daughter, Audrey Mae, arrived. Audrey has a brother and a sister to look after her.

### Going, Returning and Still Absent

**Dr. and Mrs. Wah Tin Chock** and daughter left Hilo on December 13, 1950 for Chicago. Dr. Chock will study as a resident in Pediatrics at the Cook County Hospital for a year.

**Dr. and Mrs. M. H. Chang** and family returned to Hilo after an extended mainland trip.

**Dr. and Mrs. Theodore Oto** returned to Hilo after a two month travel across the U. S. Continent.

**Dr. R. P. Wipperman** and **Dr. S. R. Brown** are still on the mainland.

A Happy New Year to all from the Hawaii Doctors and their families.

## NEWS

### ANNUAL TERRITORIAL MEETING

All doctors who would like to present papers or scientific exhibits at the Annual Meeting of the Hawaii Territorial Medical Association, May 3-6, in Honolulu, should notify Dr. Laurence Wiig or Mrs. Bennett as soon as possible. Titles and abstracts of the papers should be submitted by February 15, if it is not possible to complete the papers by that time. Papers will be limited to 15 minutes with 5 minutes for discussion.

Our postgraduate speakers will be Dr. Nicholas J. Eastman, Obstetrician-in-Chief, Johns Hopkins Hospital, and Dr. Herbert F. Traut, Professor of Obstetrics and Gynecology of the University of California Medical School.

### Honolulu Obstetrical & Gynecological Society

Recent meetings of this society included scientific papers of **Dr. Laurence G. Thoun**, who gave a talk on "Irregular Shedding of the Endometrium"; **Dr. Richard Sakimoto**, "Unusual Findings at Repeat Cesarean Sections"; **Dr. C. C. McCorrison**, "Pregnancy with Diabetes"; and **Dr. Hugh G. Hamilton**, of Kansas City, Missouri, spoke on "Serum Proteins in Pregnancy."

### American College of Surgeons Hawaii Chapter

At the fall meeting of this Society the following scientific papers were presented: **Dr. T. W. Cowan**, of Honolulu, "Pseudotumors of the Orbit: Diagnosis and

Treatment"; **Dr. S. Mizuire**, of Hilo, "Sulfonamide Nephrosis and Its Treatment"; **Dr. L. Q. Pang**, of Honolulu, "Primary Repair of Cleft Lip"; **Dr. B. O. Wade**, of Waimea, Kauai, "Intra-abdominal Neurogenic Sarcoma."

### Honolulu Surgical Society

The September meeting of this society was devoted to a study of Atomic Warfare. The program was presented by **Col. Dean M. Walker**, Chief of Surgery at the Tripler Army Hospital, and by members of his staff. Several movies of a restricted nature were shown to the local medical profession, which was well represented at this large, important meeting.

At the November meeting scientific papers were presented as follows: **Dr. Raymond Thompson**, Associate Professor of Neurosurgery at the University of Maryland School of Medicine, in Baltimore, Maryland. His paper described his experimental and clinical work on abnormal blood vessels in the brain. This was discussed by **Dr. Ralph B. Cloward**. Following this paper, **Dr. Tadao Hata**, of Honolulu, reported on the diagnosis and treatment of cancer of the throat, which was discussed by **Dr. F. J. Pinkerton**. The final paper was a very interesting presentation on "Dynamic Posture," or the posture of the body in motion, which subject has been the special hobby of the speaker, **Dr. Beckett Howarth**, Assistant Professor of Orthopedic Surgery, Columbia University School of Medicine, New York City.

**Dr. C. M. Burgess**, the retiring president of the Society, delivered an excellent address outlining work accomplished during the past year, which included aiding in the establishment of the experimental surgical research department at The Queen's Hospital. He made a number of recommendations for improvement of surgery in the Territory in the coming years.

At the election of officers for the coming year **Dr. Laurence M. Wiig**, the current secretary-treasurer, was elected to the presidency and was succeeded by **Dr. Lester Yee**.

**Dr. Wiig** has appointed **Dr. Robert G. Johnston** as chairman of the Program Committee and the following are members of the committee: **Dr. Verne C. Waite**, and **Dr. Thomas S. Maeda**, with the Secretary and President serving ex-officio. Any physician desiring to aid in the programs of this society either by presenting a paper or by information about visiting surgeons who would contribute, please communicate with members of the committee at any time so that the programs may be made increasingly interesting and valuable.

### Postgraduate Convention of College of Medical Evangelists To Be Held March 11-16

Diagnosis, Management, and What's New will be the theme of the annual Postgraduate Convention of the College of Medical Evangelists School of Medicine, to be held at the Biltmore Hotel, Los Angeles, March 11-16. It is expected that more than 2500 physicians and medical leaders from all over the United States and Canada will attend the meetings which are open to graduates of all recognized medical schools. In 1950 more than 1000 doctors from California alone attended the convention.

The six-day medical convention is especially geared to



the needs of the general practitioner. Many eminent medical speakers will bring practical and comprehensive syntheses of latest advances in medicine which can be put to immediate use. This program has been planned by a committee consisting of both general practitioners and medical school faculty.

Further information concerning the convention may be obtained by writing or telephoning Dr. Jerry L. Pettis, Managing Director, White Memorial Hospital, 312 North Boyle Avenue, Los Angeles 33, California.

### **Annual Clinical Conferences of the Chicago Medical Society**

**March 6, 7, 8, 9, 1951—Palmer House, Chicago, Illinois**

The Clinical Conference of the Chicago Medical Society is designed to bring physicians new resources to meet their problems in every-day practice. A faculty of thirty-four outstanding speakers will present half-hour lectures and another group of authorities will participate in the four Panels on timely topics.

### **ACCP Essay Contest**

The Board of Regents of the American College of Chest Physicians offers a cash prize award of Two Hundred and Fifty Dollars (\$250.00) to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest disease. The prize is open to contestants of other countries as well as those residing in the United States. The winning contribution will be selected by a board of impartial judges and the award, together with a certificate of merit, will be made at the forthcoming annual meeting of the College to be held in Atlantic City, New Jersey, June 7-10, 1951.

The College reserves the right to invite the winner to present his contribution at the annual meeting and to publish the essay in its official publication, *Diseases of the Chest*. Contestants are advised to study the format of *Diseases of the Chest* as to the length, form and arrangement of illustrations to guide them in the preparation of the manuscript.

The following conditions must be observed:

1. Five copies of the manuscript, typewritten in English should be submitted to the Executive Office of the College, 500 North Dearborn Street, Chicago 10, Illinois, not later than April 1, 1951.
2. The only means of identification of the author or authors shall be a motto or other device on the title page and a sealed envelope, bearing the same motto or device on the outside, enclosing the name of the author or authors.

Offices in Young Building, completely equipped for general practitioner, for sale or rent. For information phone 5-6893.

Kilauea Plantation Physician's position, Hanalei District Government Physician's position and private practice with fully equipped office to be available about April 10, 1951.

Combined position and practice offer an excellent income for an interested physician.

Kapaa private office and equipment for sale. Any physician interested please contact Dr. Gustave F. Bieber, Kilauea, Kauai.



Blue Shield Plan  
for Hawaii

# HAWAII MEDICAL SERVICE ASSOCIATION

PROFESSIONAL BLDG. • 1160 BISHOP STREET • TELEPHONE 53975  
HONOLULU, HAWAII

O. B. PATTERSON  
*Executive Director*

## BRANCHES

•  
LIHUE, KAUAI  
HILO, HAWAII  
WAILUKU, MAUI

*To: HMSA PARTICIPATING PHYSICIANS*

*From: DR. ROBERT B. FAUS  
Medical Director*

The HMSA is very pleased to have this opportunity to make a direct report to the participating physicians of the Association.

During 1950 the HMSA experienced claims in the field of surgical and hospital care far beyond any past period of operation.

During these months it has been my responsibility in many instances to confer with you personally and work out a mutually satisfactory settlement for services rendered. Some of these decisions have been difficult to make, however I wish to assure you that any settlement the Association has made has been given the utmost consideration.

During the coming year I wish to appeal to every one of you to work with me and the HMSA medical committee. We urge you to bear with us in our decisions because every effort has been, and will continue to be made, toward fair and just settlements. We also appeal to you in the financial interest of the association to accept *our* interpretation of contract benefits. The association cannot possibly hope to pay benefits beyond those included in the contract, and it is my personal responsibility to interpret the contract and make certain that only eligible benefits are paid.

The HMSA expects your trust, your understanding, and your consideration in the difficult period ahead.

He who wishes to travel far spares his mount!

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

---

## BULLETIN COMMITTEE

ANGELA M. CARLUCCI, *Editor*, Leahi Hospital, Honolulu  
LAURA DRAPER, *Nursing Information Committee*, Board of Health, Honolulu  
LEAH BIGELOW, *Nursing Information Committee*, St. Francis Hospital, Honolulu  
MABELCLAIRE NORMAN, *Executive Secretary*, Honolulu  
ALISON MCBRIDE, *Territorial Association Secretary*, Honolulu

### *Secretaries*

BESS HAMMER, Hawaii  
VIRGINIA RAUTENBERG, Honolulu  
PAULINE JOHNSON, Kauai  
LAURA WONG, Maui

### *Publicity Chairmen*

GRACE LUSBY, Hawaii  
HELEN GAGE, Kauai  
MICHIE KAMITAKI, Maui

---

## THE TENTH ANNIVERSARY OF THE MABEL L. SMYTH MEMORIAL BUILDING

JESSIE EYMAN, R.N.\*

On January 4, 1951 the Mabel L. Smyth building had served the medical and nursing professions and the community of Honolulu for ten years.

On February 18, 1936 a committee was appointed by the Territorial Nurses' Association "to sincerely study the advisability of establishing a nurses' center to house the Nursing Service Bureau and the Nurses' library." Miss Mabel Smyth was present at this meeting.

On March 24 Mabel Smyth passed away suddenly. Her loss to the community and to the profession was felt keenly, and served as an impetus to push forward the erection of a building which could be dedicated to her memory. Miss Smyth, as head nurse at Palama Settlement and later as Supervisor of Public Health Nurses, had the love and respect of all who knew her. Because she was an island born girl and of British-Hawaiian parentage, she was well known in the community and was influential in securing legislation of value to nurses.

Dr. Douglas Bell, at that time President of the Honolulu County Medical Society, hearing of the plans of the nurses, conceived the possibility of the doctors' and nurses' combining their efforts in a building to serve the needs of both the nursing and medical professions. This idea was acceptable to the nurses. It was with some difficulty that a suitable location for the building was found. In order for a hospital to receive a Class A rating from the American College of Surgeons, it must

have a medical library. The trustees of Queen's Hospital saw an opportunity in the Mabel L. Smyth Memorial Building to meet that requirement; therefore, after legal advice regarding the contents of the 99 year lease from the Bernice Pauahi Bishop estate, the trustees of Queen's Hospital offered to the Nurses' and Medical Associations the corner at Beretania and Punchbowl Streets. The two associations felt this location was suited to their needs and saved them an investment in real estate; they therefore accepted the offer of Queen's Hospital with thanks. Since the ground belonged to the hospital it was necessary that the deed to the building be passed to them, which deed they now hold.

On October 15, 1939, an agreement was signed by the President and Secretary of the Queen's Hospital trustees, the Territorial Medical Association and the Territorial Nurses' Association that "the building become and remain the property of the hospital but the hospital agrees that it will always be used only for the general purposes outlined and that it will not be held as a part of the hospital's plant." "Said Memorial . . . shall be under the control of a Board of Management of five members — two to be selected by the Nurses' Association, two by the Medical Association, and one (who shall not be a doctor of medicine) by the hospital."

When our purpose was made known to the general public, it was not difficult to raise the necessary funds from business interests and individuals, including the many, many friends of Mabel Smyth.

The late Mrs. Charles Adams and her daughter Mrs. Walter Dillingham generously gave the medical library as a memorial to Dr. Adams. The late

---

\* Manager, Mabel L. Smyth Memorial Building.



Ethelwyn Castle furnished the lounge, lanai and kitchen in appreciation of the services of her nurse, Miss Alice Yates. Stella Lowrey, a private duty nurse, generously left the Nurses' Association a large amount in stocks and bonds, and in appreciation, the conference room was named for her.

The air-conditioned auditorium has 341 seats, each with the name of the purchaser or of a friend. It is only from office rentals of the Territorial Medical Association, the Honolulu County Medical Society, the Territorial Nurses' Association, the Nurses's Association City and County of Honolulu, the Physicians' Exchange, the Nursing Service Bureau and the Territorial Board for the Licensing of Nurses, plus the income from the auditorium, that we have sufficient funds to maintain the building.

Plans for the future envision the building of a new wing to house various health agencies. It is also hoped an endowment fund can be built up through donations and legacies. This building has served the nursing and medical professions far beyond the visions of those who conceived the idea fourteen years ago. There is no reason why this service should not increase in scope during the next ten years.



Headquarters Office, Nurses' Association, Territory of Hawaii; and Board for the Licensing of Nurses at the Mabel L. Smyth Memorial Building, Honolulu, Oahu. Left to right: Helen Oyama, Office Secretary, Board for the Licensing of Nurses, Territory of Hawaii; Mabel Claire Norman, Executive Secretary, Nurses' Association, Territory of Hawaii, Inc., and Board for the Licensing of Nurses; Jessie Eymann, Manager of the Mabel L. Smyth Memorial Building, and Maxine McQueen, Office Secretary, Nurses' Association, Territory of Hawaii; Nurses' Association, City and County of Honolulu, and Clerk for the Board for the Licensing of Nurses.

To many of you the above photograph will serve as an introduction to the Office Staff of the Territorial Nurses' Association—and perhaps for some—your first glimpse of the office that is maintained by you. This is your office—your dues pay maintenance, expenses and salaries. To those of you from the outside Islands—come in and say "hello" whenever you might be in Honolulu. As for us—we would like to wish all of you a belated Happy New Year.

## FROM YOUR LOCAL HEADQUARTERS

Now that the Christmas Season is over and we are well into a New Year, we can all settle down to our work.

Here in this office, we have been concentrating on the membership drive and there remain still a few days before our reports must go to New York headquarters. We are hoping that our number will be greater than ever before.

Incidentally, how many of you take the *American Journal of Nursing*? The Anniversary number—Oct. 1950—was one of the most outstanding issues in many years. Yet each issue continues to improve. This is one way you can all keep in active touch with your profession and its activities. If you will get together in groups of three or more, it costs you only \$3 a year.

Even now we are thinking about our next annual convention. What do you want? When do you think would be the best time to have it? What topics would you like to have presented? All suggestions will be gratefully received.

Let's make 1951 a Red Letter Year in this Association!

MABELCLAIRE NORMAN, R.N.  
*Executive Secretary*

## FEAR AND HOW TO COPE WITH IT

CLAIRE CANFIELD, R.N.\*

Fear is a primitive, elemental reaction of man, unquestionably antedating historical recording. The subject matter of fear has varied with changing cultures. The gamut of fear-producing subjects includes natural events such as thunder and lightning, earthquakes and volcanic eruptions; religious speculations, the anger of the gods, the end of the world, witches and the evil eye are all types of fear-producing ideas which have dogged mankind. Always the kernel is an idea for a thought. With changing cultures and levels of education and civilization the ideas most productive of fear change, but their devastating effects continue. Today we live in a fear-ridden world—thoughts of widespread war, atomic bombs, financial depressions, inflation, and political upheavals are distressing many. These are more or less generalized subjects and, while matters of real concern, they lack the poignancy and intimacy of purely personal fears which are much more devastating.

We are aware of the physiologic and psychologic mechanisms involved in fear. Acute attacks are called panic and produce marked changes in body functions, temporarily at least; the more sustained, the chronic types produce anxiety with

\* Mental Health Nursing Consultant, Dept. of Health.

milder disturbances of the physiologic states, but are nonetheless effective in upsetting the mental, emotional and physical equilibrium.

We doubtless readily agree that man is prone to the development of fear and anxiety states. There is ample substance to create fear in these troubled times. However, it seems relatively safe to say that in our culture and civilization malignant disease holds an extremely high rating as a cause of fear.

Cancer is a vicious word; it connotes much more than a killing disease. It suggests mutilation, disfigurement, pain, long drawn out suffering, financial distress, hopelessness. Such ideas about cancer are rather universal. In our own medical jargon, the words "malignant disease" have a sinister connotation.

Fear undoubtedly is the greatest obstacle to be overcome in the campaign being waged against cancer. It is probably the greatest deterrent to early diagnosis and treatment wherein the present hope of control lies.

The development of cancer is one of the emergencies of life which puts to a real test the total resources of an individual. What the individual does about this threat to his life is usually characteristic of the manner in which he has met other crises.

Some patients appear to accept the verdict with equanimity, even in a casual manner. Frequently this is a mask employed to disguise real feelings or an attempt to keep them under control. Other patients attempt to repress their concern; they avoid facing the issue; they deny to themselves that anything is wrong; they hesitate to call on a doctor. An eminent psychiatrist in Boston has made this statement: "The capacity of man to deceive himself or to avoid the unpleasant truth is shown perhaps nowhere more clearly than at a cancer clinic."

We ask ourselves: why do people react so differently to serious threats? It is really not essential to have this understanding in order to help people meet the problems related to their illness and need for medical care. It is, however, of the utmost importance that we who attempt to help people have the capacity to perceive individual differences in patients and to be aware of the patient himself as well as the malignant lesion which threatens his life.

But first we need to sort out our own feelings about cancer, for unless we clarify our own thinking and feeling about the disease we cannot develop a helpful relationship with the patient. The attitudes of those in the environment toward cancer are of the utmost importance. Sometimes our

own feelings about the disease cause us to desert the patient when he needs us most. A patient may have a disfiguring scar or loss of a member. He may have to learn to use and care for an artificial leg, a plastic jaw, a rubber nose or an artificial eye. He will be on the alert to the reaction of the nurse both before and after he obtains the appliance. If she shows any unfavorable reaction his whole adjustment to his condition and to his return to his family may be affected. "For," he reasons, "if the nurse, who by training and experience is accustomed to seeing patients in this condition, flinches at the sight of me, how can my family and business associates be expected ever to accept me?"

Resistance is often due to lack of factual information; we need to know more about the nature of cancer, possibilities for treatment and curability. This will do much to help us accept cancer just as we do tuberculosis or heart disease. We should be aware of the progress which has been made in the field—aware that more patients come for care, and when cancer is localized and curable we should be aware of the uses of surgery, x-ray, and radium, and that these measures also may not only prolong life in advanced cancer but often maintain patients in comfort and even in activity. Nor must we think that terminal cancer is synonymous with continuous pain. Patients can be kept relatively comfortable.

We are more aware of the patient himself when we are able to separate our feelings from those of the patient, and are thus able to be more helpful to him in his crisis. We can then see the patient, not as the pitiable victim of a hopeless disease, but as an individual who is faced by a life situation which is threatening to his security, happiness and comfort.

Because the nature, causes, and probably outcomes of cancer are usually "unknowns" for the patient it requires the greatest security on his part to be able to put himself in the hands of others upon whom then he is dependent for his welfare. Even when he manages to take this primary step his inner self may really not be able to take the chance and his energy is consumed by fear and worry so that he is actually not able to participate in plans for care and treatment. This will be all the more difficult for a patient if he is essentially a distrustful person and suspicious of other people's intentions.

Perhaps our most potent weapon in dealing with the disturbing factor of fear in cancer is to create somehow in the person a hopeful attitude. Hope is one intangible which must be captured. It emanates from the attitudes of those in the en-



vironment and is subtly conveyed to the patient. Courage, cheer, and hope do have infectious qualities, and attitudes displayed in gestures and words said and left unsaid may make the difference between misery and relative comfort for the patient.

Various factors influence the degree to which a patient is able to seek out help. Inaccessibility to reliable help grows to be less and less a factor with the increase of professional and public effort directed toward the problem of cancer control. Financial limitations on the surface seem less significant than formerly as communities more and more assume responsibility for free care. Inability to pay, however, even when free care is available, may be frightening to some patients because it may imply loss of control of the situation. As one patient so aptly put it: "I'd be much surer of what I'm a gettin' if I could lay my money on the counter." Many patients in their minds relate the ineffectiveness of treatment to their inability to purchase the kind of help which they feel would save them. Money always represents one means of buying safety, and for some money has unusual significance.

Another factor which has real meaning for the individual who finds himself confronted with the cancer is the nature of his previous experience with it, in either himself or someone close to him. One learns in dealing with patients the emotional significance for them of the presence of cancer in another member of the family. If their contact with the person has been a close one the possibility of deep emotional involvement is very real indeed. If death has occurred the impact of the experience will be much greater.

Family and social responsibilities will often loom as almost insurmountable obstacles, i.e., a mother with small children who are dependent on her for care, or a father with family and business obligations.

These are merely some of the many factors which may influence a patient when he is suspicious or relatively sure of cancer and they give us some notion of the ambivalence, resistance and fear of the unknown which he in all probability feels when he is confronted with the need to do something about himself.

It is at this point that significant service can be rendered in giving to the patient the support and security he needs. We must not minimize the validity of his fear, but rather encourage him to express his doubts, fears, and anxieties about the experience, even the possibility of death. Often it is a great relief for a patient to express these things and to share them with someone. We need to listen to the patient uncritically and be sympa-

thetic in manner; otherwise we may discourage the patient from revealing feelings that are essential to an understanding of the total problem and his personality. Attention needs also to be paid to the behavior of the patient and to the actual words he uses in describing his complaints as well as the asides and irrelevancies that so often give important clues to his emotional state. Give the patient time to talk and manage as few interruptions as possible. "Listen rather than talk to patients" is a pertinent course to follow. It is "listening" with a purpose, however.

Whether the choice of treatment has been surgery or irradiation, good psychologic preparation is important. This includes interpretation of disabilities which may arise as a result of treatment. For example, explanation to the patient about to have a laryngectomy that he will be unable to speak following surgery or the patient who is to have a colostomy—that bowel function will take place through an abdominal opening, etc. Giving the patient some notion of what is going to happen to him and an adequate explanation of possible procedures such as blood transfusions, intravenous fluids, use of oxygen, etc., does much to allay his doubts, fears and uncertainties.

We should also be alert and aware that the patient may have feelings regarding the accuracy of diagnosis and choice of treatment. Often more detailed and simplified interpretation helps.

In the early stages of recovery, if the patient's condition permits, it is good to stimulate activity, for it is easier to maintain activity than to resume it when once it has been curtailed. Early ambulation is beneficial psychologically as well as physiologically. Teach the patient to take care of himself; this often reactivates independent self-esteem and hope in the patient. Encourage him to participate in recreational and occupational pursuits which are available and adaptable to his needs.

We all know that hospitalization entails temporary isolation and retreat. It means separation from one's family with feelings of being alone and estranged. Effort can be directed toward minimizing these feelings through activities and contacts with other patients. Dramatic results may accrue in such cases when patients of similar nationalities, or with mutual problems, are placed next to each other in wards. They not only can and do learn from each other, but gain comfort and reassurance in sharing with someone else who is in a similar predicament. Being a member of a group gives the patient a sense of belonging and helps him to continue relating to people.

The nurse's knowledge that there is much hope in cancer will fortify her in approaching patients.



This will also influence the family whose attitudes are important factors in the patient's well being. Not only this, but an awareness of the patient's personality-in-illness and knowledge of what the illness means to him will serve her well in helping the patient and his family. Some families have inner resources for meeting calamities—others will need considerable interpretation of the patient's needs and his disease before they can continue to lead normal lives and give the patient the support he should have. The nurse can motivate the family through her knowledge of the disease and a sympathetic appreciation of the problems involved.

Finally, however, in dealing with the cancer patient and helping him to cope with his fears, there are no pat answers. There is no special technic, no uniform approach. Each patient is unique in the problems he brings and the help he needs. Generalizations are unsound. Our need is to understand the patient with his cancer; our need is to develop the capacity to see beyond the lesion to the person whose cancer it is; and our need is to view the cancer through the eyes of the patient as well as our own; but most of all, perhaps, to somehow stir within the patient hope and courage to face his crisis.

### References

1. Cockerill, Eleanor, "The Social Worker Looks at Cancer," *The Family*, February 1937.
2. Cockerill, Eleanor, "The Patient Has Cancer," *Public Health Nursing*, October 1943.
3. Cockerill, Eleanor, "The Cancer Patient as a Person," *Public Health Nursing*, February 1948.
4. Ferguson, Marion, R.N., "The Public Health Nurse and the Cancer Program," *Public Health Nursing*, July 1948.
5. Keller, Caroline, "Raising the Cancer Patient's Morale," *American Journal of Nursing*, August 1948.
6. Kempf, Florence C., "The Person as a Patient," *The Modern Hospital*, June 1948.
7. Solomon, Harry C., "Psychiatric Implications of Cancer," *Rocky Mountain Medical Journal*, October 1947.
8. Weiss, Edward, "Psychotherapy in Everyday Practice," *Journal of the American Medical Association*, May 29, 1948.

### CANCER NURSING INSTITUTES

DOROTHY G. TEALL, R.N.\*

Cancer Nursing Institutes were held on the islands of Hawaii, Maui, Oahu, and Kauai from October 16 to October 25, 1950. Public health, hospital, school, industrial, clinical, private duty, and inactive nurses attended.

Miss Rosalie Peterson, Senior Nurse Officer, National Cancer Institute, came to the Islands for one month to help launch the Cancer Nursing Educational program. Miss Dorothy Teall, Cancer Nursing Consultant, with the Territorial Department of Health, with the help of a nursing committee from each island Nursing Association

planned the programs. The program was sponsored by the National Cancer Institute, the Hawaii Cancer Society, the Territorial Department of Health and the Territorial Nurses' Association.

Although the subjects discussed and the demonstrations presented varied some for each island program, the following is a summary of the main points presented: Dr. Walter Quisenberry, Chief of the Bureau of Venereal Diseases and Cancer Control, discussed the cancer problem in Hawaii. He stated that cancer is second only to heart disease as a cause of death in Hawaii, and as the population grows older more cases will occur.

In an analysis of the deaths by races, he pointed out that the highest rate of deaths were among the Hawaiians; next, part-Hawaiians; 3rd, Japanese; 4th, Filipino; and 5th, Caucasians. One of the reasons Hawaiians take first place is that they usually report to medical attention late in the course of the disease and sometimes not at all.

In cancer of the breast, the Caucasian has the highest rate of deaths, Japanese and Chinese are low, and Filipino is very low. What is the solution?

1. A good educational program for the lay public, so that more people will report for physical examination even without symptoms.
2. A good educational program for physicians in order to help them with the diagnosis of cancer.

He further stated that one-half of the deaths from cancer today are needless and one-third could be saved if the diagnosis was made early.

Miss Peterson discussed the role of the nurse in cancer control. She focused her topic specifically on breast cancer and its early detection. She explained that there are 50,000 new cases of breast cancer each year, and there are 20,000 deaths each year from this disease. Twenty per cent of all cancer in women is of the breast.

She pointed out that the first symptom may be a painless lump in the breast or axillary nodes; although only one out of three such lumps found will be cancerous, the only sure way to determine if the lump is malignant is to go to a physician who will remove the lump and do a biopsy.

She said that nurses have a golden opportunity to save life by encouraging all women to do breast self-examination as a regular health habit.

The film, "Breast Self-Examination," was shown. This film is a new teaching device. The technic of self-examination is presented clearly and simply. The aim is to show this film to as many women as possible within the next year. Breast self-examination can be done by every woman as a routine health habit. It should be

\* Cancer Nursing Consultant, Dept. of Health.

done once each month following the menstrual period.

A question and answer period followed the showing of the film.

Miss Peterson also discussed post-operative care of the patient following a radical mastectomy. This operation includes the removal of the entire breast, as well as the regional lymph nodes. It is also necessary to remove the overlying skin, the superficial fascia, the fascia overlying the intercostal muscles, and both the pectoralis muscles, major and minor. For a good recovery following surgery, the patient will need to start exercises a few days after operation in order to train new muscles to work. This is a painful task for the patient, and the nurse can do much to encourage her by showing her the simple method of crawling up the wall with her fingers, combing her hair, etc. The nurse may be instrumental in getting the cooperation of the patient's family too in encouraging the patient to learn to help herself.

If radical surgery is necessary, a breast prosthesis can be made to fit, as well as to match the exact size and shape of the opposite breast. Samples of prostheses were shown. The emotional problems of the cancer patient and family were discussed by Miss Claire Canfield, Mental Hygiene Nurse Consultant, with the Territorial Department of Health. Her paper on "Fear and How to Cope with It" is also presented in this issue.

## OPINIONNAIRE

MARGARET NOTT, R.N.\*

Too often those who attend meetings do not have the opportunity to express their opinions regarding the material presented and the method of presentation. How many times have you griped because a speaker was dull and there was no one to whom you could complain? The Cancer Nursing Institute Committee of the City and County Nursing Association provided a questionnaire at the recent institute so that those who attended could express their opinion. Do you want to know the outcome? Here it is:

1. The "general Value I have gained."  
Little—0      Moderate—21      Much—63
2. "Specific Value I have gained."  
Little—1      Moderate—24      Much—53
3. The particular topics that have helped me:

	Least	Most
The Role of the Nurse in Cancer Control.....	4	52
The Cancer Problem.....	2	38
Problems of the Patient and Family.....	6	35
Rehabilitation of Cancer Patients.....	5	27
Treatment of Cancer of Breast.....	4	43
Cancer of the Cervix.....	6	33
Cancer of Gastro-Intestinal Tract.....	0	0
Care and Treatment of Patients with Colostomy	0	0

\* Director of Nurses, Kapiolani Maternity Hospital.

## 4. Methods of presentation that have helped me.

	Least	Most
Films .....	3	55
Discussions .....	4	50
Lectures .....	5	46
Demonstrations .....	4	18

Those who attended were also asked how the meeting could have been improved. Of the many proposals some were:

## 5. Points of weakness I see in the program:

	Least	Most
Too few subjects .....	0	6
Too many subjects .....	0	3
Too many lectures .....	0	34
Too few demonstrations .....	0	1
Too little discussion .....	0	10
Too much discussion .....	0	1
Lectures too long .....	0	1
Some thought it was very good as it was.		

In addition to comments on the institute the committee asked for suggestions for future programs. The results indicate that Oahu nurses are eager for more study. Proposed subjects include:

Cancer in children—Age 5-14.

Cancer — Skin, Bone, Lung, Gastro-intestinal tract; Cancer tumors and cell study (cytology).

Other subjects for institute study not in the cancer field include:

First was — Heart, then Polio, Tuberculosis, Geriatrics.

Other institute suggestions were to have more evening meetings. More lectures and films. More audience participation; presentation of actual cases; technical lectures in a.m. Movies and demonstrations in p.m.

Since so many nurses expressed the desire for more institutes, those who worked on the committee propose that a permanent committee be formed and established to plan future programs.

The representation at the institute was as follows:

Institutional nurses .....	70
Public Health nurses.....	43
Private Duty .....	15
Inactive .....	35
Practical nurses .....	31
R. N. Unclassified.....	6
Industrial .....	5
School nurse .....	1
Office nurse .....	3
Occupational Therapist .....	1
Anesthetist .....	2
Med. Social Worker.....	2
Physician .....	1
Navy Relief Nurse.....	1
Executive of Territorial Association.....	1

## EDITORIAL

Do we want Social Security in our Institutions? I do—What about the rest of us? For the first time in the history of our profession the public through our government is taking an active interest in helping us to provide for the time when



we no longer will be able to provide for ourselves. I look with horror to the "Old Ladies Home"—I want my apartment—I want to continue to live as an independent individual even after I am 65 years old and I firmly believe that this Amendment is part of the answer to the problem of Economic Security for the later non-productive years.

Perhaps the following highlights will help clarify the Amendments to the Social Security Act signed by President Truman, August 28, 1950 and due to become effective as of January 1, 1951.

The majority of registered professional nurses will now be covered by the Act either on a compulsory basis or on a voluntary basis as follows:

a. Self-employed professional nurses on a compulsory basis if they earn a new annual income of \$400.00 a year;

b. Nurse employees of non-profit institutions, with the exception of members of religious orders, if (1) the employing organization or institution, files a certificate that it desires extension of coverage to its employees, and (2) two-thirds of the employees concur in the filing of the certificate, and (3) their signatures are on a list accompanying the certificate. (Employees hired at a later date will also be included in coverage. Under provisions of the law, social security on this employer-employee elective basis will be available to: "Any charitable, or religious institution or any educational, religious, scientific or literary organization, no part of whose earnings go to the benefit of any private shareholder or individual");

c. Federal Government employees not under Federal retirement system;

d. State and local government employees under an agreement negotiated between the states and the Federal Security Administrator if they are not now covered by a retirement system.

Tax rate on wages for employer and employee will be  $1\frac{1}{2}\%$  on the first \$3,600 of annual income (the maximum wage credits allowed a worker for a calendar year) in 1950-1953;  $2\%$ , 1954-1959;  $2\frac{1}{2}\%$ , 1960-1964;  $3\%$ , 1965-1969; and  $3\frac{1}{4}\%$ , 1970 and thereafter.

Self-employed persons will pay  $1\frac{1}{2}$  times the above rates. Private duty nurses with a new annual income of \$400 or more will be required to file an income tax return and pay the tax, which will be handled as an integral part of her income tax.

To qualify, an individual must be "fully insured." To be "fully insured" he must have a credit of (a) 40 quarters of coverage or (b) one-quarter of coverage, acquired at any time, for each two-quarters elapsing after 1950 up to, but ex-

cluding, the quarter in which he attains the age of 65 or dies. However, he will not be fully insured unless he has at least six quarters of coverage.

Supplementary benefits are provided for aged husbands, wives of insured persons, and dependent children under age of 18. Survivors' benefits are provided for widows, widowers, children and aged dependent parents of deceased employees. The amount of the lump sum death benefit has been increased.

### BLOOD DONORS WANTED

Three thousand donors are needed to create a supply of blood for the Blood Bank of Hawaii to be used for the vital phases of disaster relief.

The Volunteer Placement Bureau, in charge of the program, can be contacted at 1388 Lusitana Street, will provide speakers for group meetings and arrange for donations.

This is an urgent situation—just phone 51-0115 for further details.

### SCHOOL NURSE SECTION

At the October meeting of the School Nurses' Section, held at Waioli Tea Room, Olga Larson from Farrington High School was elected chairman for the coming year. Other officers for 1950-51 include Violet Farm from the Central Union Preschool who will serve another year as secretary; Lillian Latus from Mid-Pacific Institute will be program chairman and Virginia Jones, University of Hawaii, will again be advisor for the group.

The School Nurses' section had charge of the November program for the City and County Nurses' Association. The theme of the program was "The Nurse Helps the Teacher." Mrs. Lucy Farden, Senior 2nd Vocational Counselor at Farrington High School, who has been with the D.P.I. for twenty-five years, gave examples of how the institutional nurse, the Department of Health Nurses and the Department of Public Instruction nurses have helped individual children in making better personality adjustments through improved health. Loretta Shuler showed (Metropolitan Life Insurance Company) slides on "Teacher helps" in observing physical symptoms of children which may interfere with growth and learning.

The next School Nurses' Section meeting will be held on Friday, Nov. 24, in the form of a beach party and luncheon at the Uluniu Club in Wai-kiki. A business meeting will follow the luncheon at which time the economic security program which has been studied by a committee of three will be presented for group discussion and action.



## PRACTICAL NURSES' ACTIVITIES

The Territorial Practical Nurses' Association was organized March 15, 1949 by the Practical Nurses' Alumnae. Mrs. Patience Martelon, who is Director of Nursing at Leahi, helped with the organizing of the Association.

Mrs. Katie Chun, who was president that year, is to be congratulated for the splendid work she did towards starting the Association.

During the first year the important thing was to get members. I think that we have done very well. We have at present 100 full fledged members who have paid their dues and membership fee. Many more have signified their intention of becoming members.

Our Constitution and By-Laws were drafted, approved and accepted.

We also have had an educational program covering mental hygiene, tuberculosis, cancer nursing and the showing of a nutrition film.

Now we are starting our second year with Mrs. Lydia DuPont as president and Miss Laura Draper as advisor.

Some of our plans for this year are, to continue increasing the membership, to continue with our educational program, and to consider being members of the National Association.

## PRACTICAL NURSE TRAINING

MRS. M. ELLIOTT

An informal graduation ceremony was held on Friday, November 10, for the 8th group of students to complete the ten months training course for practical nurses given by the Vocational Division of the Department of Public Instruction.

Among the 23 students to graduate were 2 men, the first in the Territory to complete this course. Three more are continuing their training.

A reception for graduates and supervisors in affiliating institutions was held immediately following, in the class rooms on the McKinley campus.

Students graduating were:

Miss Nora Abe—Oahu  
Miss Jane Aihara—Oahu  
Miss Lorraine Anthony—Oahu  
Miss Leonora Bulusan—Kauai  
Miss Auria de Lara—Oahu  
Miss Gertrude Dias—Oahu  
Miss Theresa Fujitani—Kauai  
Miss Eleanor Ige—Oahu  
Miss Ernestine Ikemoto—Oahu  
Miss Ellen Kimoto—Oahu  
Miss Alice Kiyohiro—Oahu  
Mr. Pedro Lacambra—Oahu

Miss Katherine Miguel—Maui  
Miss Marian Miyashiro—Oahu  
Miss Emiko Mori—Kauai  
Mrs. Kathleen Moses—Hawaii  
Mrs. Isabelle Musselman—Oahu  
Miss Mabel Okamoto—Oahu  
Mr. Ben Pitoy—Hawaii  
Miss La Paz Samonte—Maui  
Miss Yaeko Shibuya—Hawaii  
Miss Louise Silva—Hawaii  
Miss Dolores Ulanday—Kauai

## CIVILIAN DEFENSE TRAINING FOR NURSES

Three nurses were nominated by Acting Governor Oren E. Long to attend the Institute on Nursing Aspects of Atomic Warfare in San Francisco February 12 to 16, 1951. These were Miss Virginia Jones, associate professor of public health nursing, University of Hawaii, Mrs. Rosie Kim Chang, assistant director of Nursing, Queen's Hospital, and Mrs. Virginia Ahrendt, resident nurse, Pan American Airways, Honolulu. Money was appropriated by the Board of Supervisors, City and County of Honolulu, for the expenses of two nurses. Pan American provided transportation for Mrs. Ahrendt.

## 1952 BIENNIAL

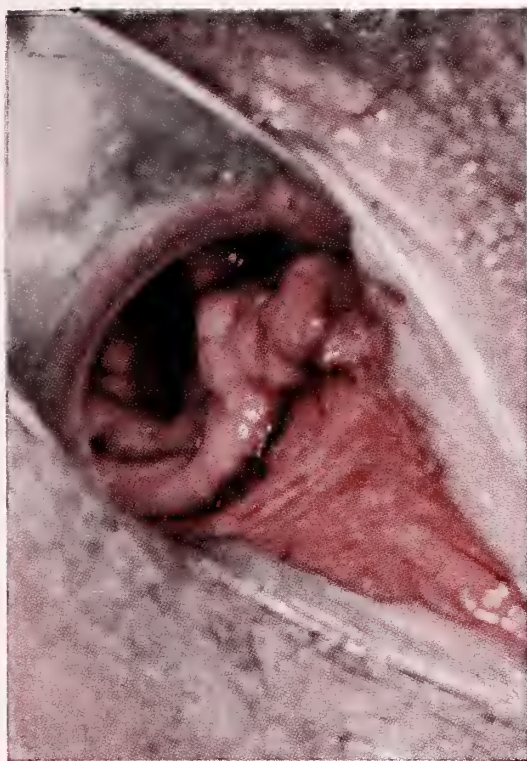
Are you saving your dollars? The 1952 Biennial Convention of the American Nurses' Association will be held in Atlantic City, N. J., June 16-20, 1952. Are *you* going? Let's send an even bigger delegation this time.

## FOUR NATIONAL ORGANIZATIONS MOVE FROM 1790 BROADWAY

As of January 1 the address of The American Nurses' Association, *The American Journal of Nursing*, The National League of Nursing Education, and The National Organization for Public Health Nursing is 2 Park Ave., New York 16, N. Y. Read the January 1950 *American Journal of Nursing* for the complete story.

## NURSES' ASSOCIATION, DISTRICT OF OAHU

On January 8, 1951, at their annual meeting, the Nurses' Association, City and County of Honolulu, voted to change the name of their organization to NURSES' ASSOCIATION, DISTRICT OF OAHU. As of January 15 the District Association will have their own telephone and the number will be 52-2255.



a. Ulcerative amebiasis during Diodoquin therapy. In this patient with severe hemorrhage, edema and necrosis, the ulcers show healing, with many scars. No active lesions are seen.



Photographs courtesy of Louis H. Block, M. D., Chicago

b. Three months later, after continuing Diodoquin therapy, extensive scarring indicates healing. Inflammation is further reduced and only superficial areas of inflammation remain.

**AMEBIASIS:** "Diodoquin is probably the least toxic of the drugs and contains the most iodine."<sup>1</sup> "Diodoquin now appears to us to be the drug of choice [for outpatients] because of its effectiveness and because it is tolerated well by most patients."<sup>2</sup>

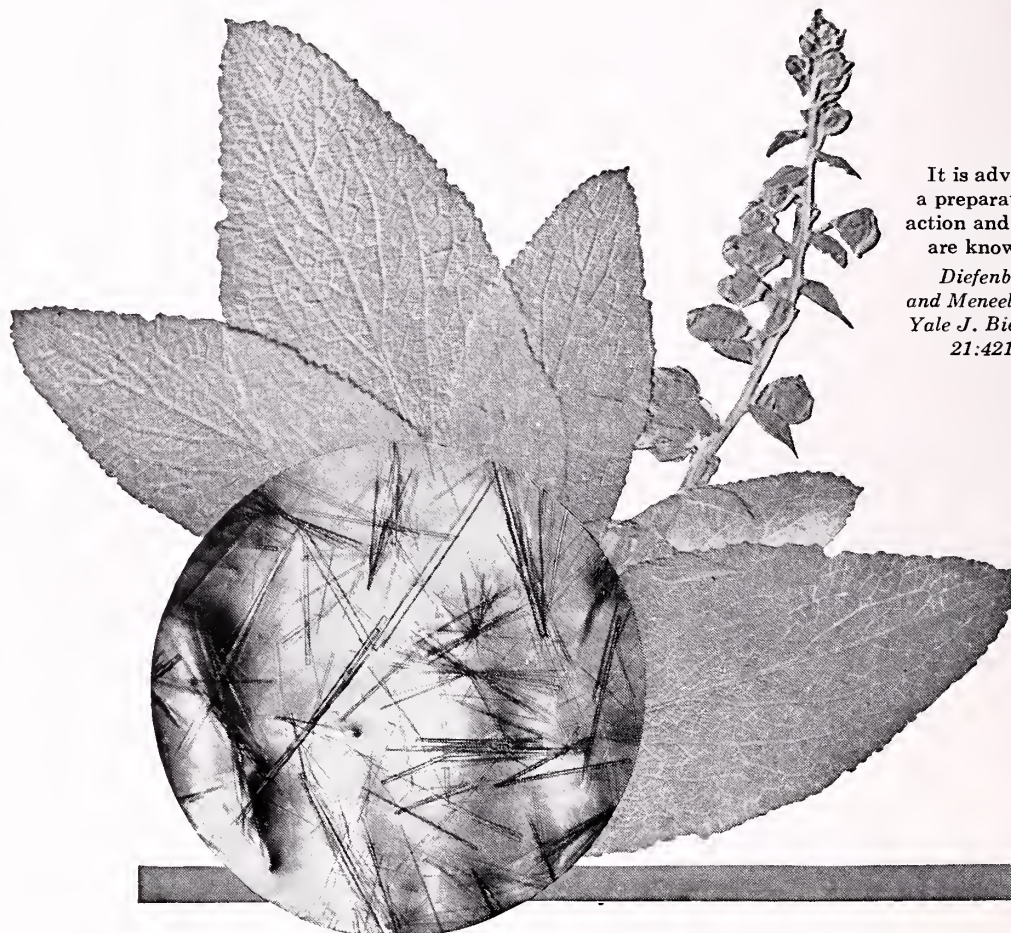
In acute or latent forms of amebiasis, Diodoquin® (diiodohydroxyquinoline) the potent amebicide, may be administered in large dosage over prolonged periods. Diodoquin contains 63.9 per cent of iodine... is tasteless... relatively nontoxic... orally administered.



1. Johnson, S. K.: Mississippi Doctor 27:69 (July) 1949.

2. Merritt, W.: J. Florida M. A. 35:351 (Dec.) 1948.





It is advisable to use a preparation whose action and potency are known.

*Diefenbach, W. C.,  
and Meneely, J. K., Jr.:  
Yale J. Biol. & Med.  
21:421, 1949.*

Uniform action... fully effective orally

## PURODIGIN®

CRYSTALLINE DIGITOXIN, WYETH

PURODIGIN has uniform action... simplifying the problem of adjusting therapy to the needs of the individual patient.

PURODIGIN is fully active by mouth... because it is completely absorbed.

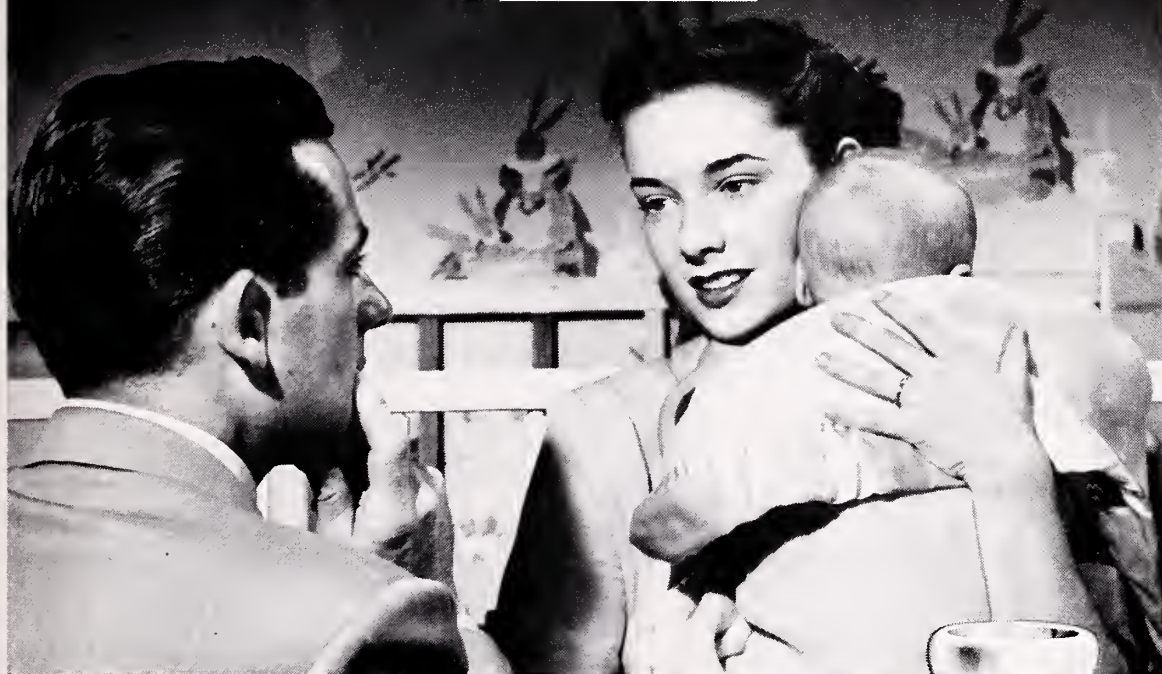


®  
WYETH  
INCORPORATED  
Philadelphia 3  
Penna.

*FOR FLEXIBILITY AND PRECISION OF DOSAGE, PURODIGIN is supplied in graduated potencies: Tablets of 0.1, 0.15 and 0.2 mg.*



**"My doctor just said 'evaporated milk'  
—I wonder which brand he meant?"**



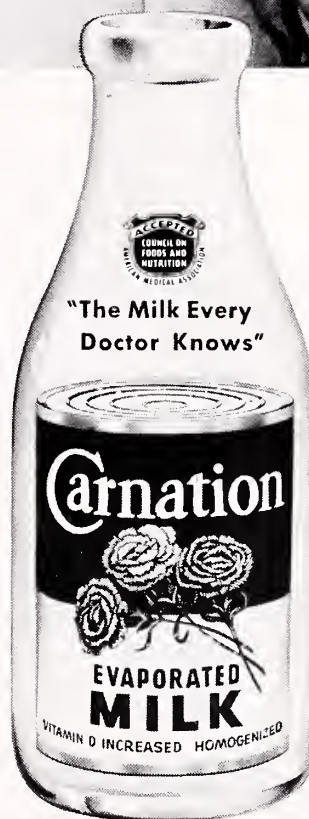
***There are Several Hundred Brands...***

**BUT ONLY ONE CARNATION!**

UNFAMILIAR brands of evaporated milk *may* be safe and uniform...but you're *sure* when you say Carnation. For generations, Carnation with water and carbohydrates has been recommended for infant feeding by America's leading doctors and hospitals.

And Carnation protects your recommendation with rigid standards of safety, uniformity and nutritional value. Every drop is processed with "*prescription accuracy*" in Carnation's *own* plants. From cow to can, Carnation Milk is constantly under Carnation's *own* supervision and inspection to make sure that it meets the exacting requirements of the medical profession.

Doctors know that Carnation is *one* evaporated milk that is readily available everywhere...*one* brand that is *always the same* wherever mothers buy it. No wonder 8 out of 10 mothers who use Carnation say, "*My doctor recommended it.*" It is the milk you can prescribe *by name* with complete confidence.



**DON'T SAY "EVAPORATED MILK"— SAY**

**Carnation**

**"from Contented Cows"**

**new DURABILITY new CLEANLINESS**  
**new COMPACTNESS new BEAUTY**



This compact case is made of reinforced material to withstand far more stress and wear than any case will receive in normal use. It has amazing resistance to scratches and abrasion, and retains its like-new appearance for years.

The soft rubber lining protects the instrument against shock damage. Like the entire case, it can be washed with soap and water and sterilized by wiping with alcohol, an impossibility with old style plush-lined cases.

The "Sandura" case takes up less room in your bag and slips easily into your coat pocket.

All Welch Allyn otoscope sets or otoscope-ophthalmoscope sets with large handles are now available in this new "Sandura" case. Cases may also be purchased separately.

*Territorial Agents*

**HOTEL IMPORT COMPANY**

*Wholesale Druggists and Hospital Purveyors*



A Division of  
**VON HAMM-YOUNG COMPANY**  
 Cooke and Kawaiahao Sts.

Honolulu

Phone 6-3561





As it has for sixty-five years, Pet Milk Company will continue to look for new ways to improve its product . . . and contribute to the nutritional welfare of the nation—especially the nation's babies. Constant research is one of many reasons why the medical profession can be assured that *when better evaporated milk is made*, Pet Milk Company will make it!

Sixty-five years ago, the first completely safe milk for babies—evaporated milk—was developed by Pet Milk Company. The new process destroyed the germs of disease which often made cows' milk a dangerous food for babies.

At the same time, Pet Evaporated Milk proved to be more easily digested than other forms of milk. Heat sterilization so changed the nature of the protein that it became soft and friable, resembling human milk in digestibility.

Then, Pet Milk was homogenized to distribute its butterfat evenly. Every drop was made uniformly rich in *all* the food values of milk.

When research proved that addition of vitamin D to milk would prevent rickets and promote optimal growth, Pet Milk was fortified with the recommended level of 400 units of vitamin D to the quart.

Later, when pure crystalline vitamin D<sub>3</sub> was developed Pet Milk was the *first* to use this improved form of vitamin D for the fortification of milk.



**Favored Form  
of Milk for  
Infant Formula**

**PET MILK COMPANY, 1424-A Arcade Building, St. Louis 1, Mo.**



## POSITIVE CLINICAL FINDINGS IN CEPT

*In Amebiasis (E. histolytica)*

"In daily doses of 1.0 and 2.0 grams by mouth for ten days, terramycin therapy resulted in the disappearance of *E. histolytica* from the stools of all but one of 22 patients.

Parasitic relapse occurred in this individual on the eleventh day after treatment, whereas in the remaining 21 subjects, the stools have remained negative to date."

Most, H., and Van Assendelft, F.:  
Ann. New York Acad. Sc. 53:427 (Sept. 15) 1950.



CRYSTALLINE  
**Terramycin**

Clinical findings covering a wide range of bacterial and rickettsial as well as several protozoan infections indicate that:

- 1. Terramycin may be highly effective even when other antibiotics fail.*
- 2. Terramycin may be well tolerated even when other antibiotics are not.*

## TIONS OF THE GASTROINTESTINAL TRACT

*In Dysentery*  
*due to Shigella paradysenteriae*

Six cases, Terramycin treated—

“The diarrhea, which was pronounced in each case, stopped within 48 hours in the case of four patients and within 72 hours in the other two. . . . In all cases, the organism disappeared from the stool after treatment was started and did not reappear.”

Dowling, H. F.; Lepper, M. H.; Caldwell, E. R., and Spies, H. W.:  
Ann. New York Acad. Sc. 63:433 (Sept. 15) 1950.

mycin

HYDROCHLORIDE



**Dosage:** On the basis of findings obtained in over 150 leading medical research centers, 2 Gm. daily by mouth in divided doses q. 6 h. is suggested for most acute infections.

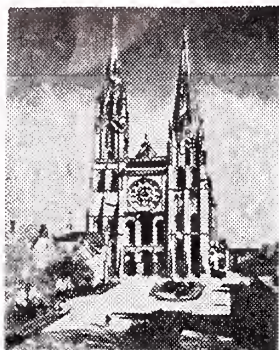
**Supplied:** 250 mg. capsules, bottles of 16 and 100;  
100 mg. capsules, bottles of 25 and 100;  
50 mg. capsules, bottles of 25 and 100.



**Antibiotic Division**

CHAS. PFIZER & CO., INC., Brooklyn 6, N.Y.





Chartres Cathedral

## VISIT 11 COUNTRIES

England	Scotland
Denmark	Belgium
Norway	France
Sweden	Germany
Holland	Italy
	Switzerland

WORLD-WIDE  
IN SCOPE

# Let's go to EUROPE in 1951

**HAWAII'S OWN TOUR** departs Honolulu June 13  
via S.S. Lurline

Thrill to the Old World in company with people from Hawaii. You may choose a tour extending 58 days, 69 days, or 81 days. All accommodations guaranteed.

from **\$2079.80** plus tax

International Travel's 1951 Tour to be personally conducted by Mrs. Ruth Ross, Hawaii's only experienced European tour-conductor.



## INTERNATIONAL Travel Service

King at Bethel Streets Honolulu Ph: 59517-67558

Waikiki Branch Outrigger Arcade Between

Royal and Mauna Hotels Ph: 93344-991514

Hilo Hilo Hotel Building Ph. 5328



## ROUGH HANDS FROM TOO MUCH SCRUBBING?

Soothe rough, dry skin with AR-EX Chap Cream. Contains healing ingredient, carbonyl diamide. Aids severely chapped and broken skin. Pleasant to use. Scented or Unscented. Send for sample.

AR-EX COSMETICS, INC., 1036-J W. Van Buren St., Chicago 7, IL.

*When little patients get*

# high handed

It isn't necessary any more to fight down a bitter tasting medicine like penicillin. Simply prescribe *Dulcet* Penicillin Tablets—the little cubes that look, smell and taste like candy.

Children think they are candy. But the penicillin is there—50,000 or 100,000 units of it, depending on which of the two available strengths you prefer—buffered

with 0.25 Gm. of calcium carbonate. *Dulcet*

Tablets are stable and have the same antibiotic

power as equal unitage of penicillin in

unflavored preparations. For your next little

patient—or finicky big one—try this

tantrum-quelling, pleasant method of

administering oral penicillin. Pharmacies

everywhere have *Dulcet* Penicillin

Tablets in bottles

of 12 and 100. **Abbott**

*Specify*

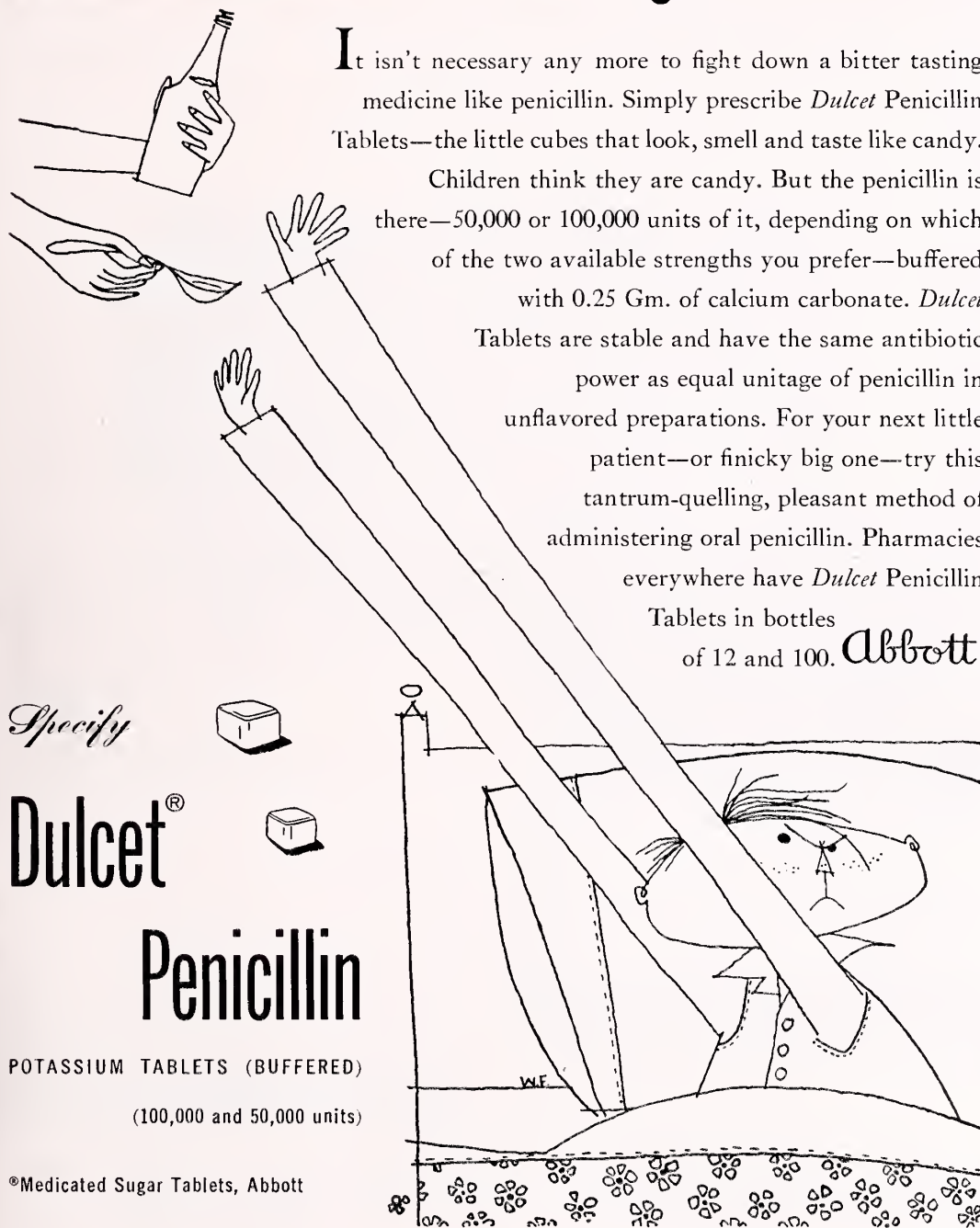
**Dulcet<sup>®</sup>**

**Penicillin**

POTASSIUM TABLETS (BUFFERED)

(100,000 and 50,000 units)

®Medicated Sugar Tablets, Abbott



# BIRTCHEE

## BLENDTOME

### Portable Electrosurgical Unit

... a MODERN LOW-COST SURGICAL UNIT for all minor and various major surgery.

The Birtcher BLENDTOME is a surprisingly practical unit for office surgery. With this lightweight unit, you have *all* the electrosurgical procedures of major units — electro excision, desiccation, fulguration and coagulation. While not meant to be compared to a large hospital unit, the BLENDTOME has been successfully used in many TUR cases. Such facility indicates the brilliant performance of the BLENDTOME.

#### ALL 4 BASIC SURGICAL CURRENTS

1. Tube Generated Cutting Current.
2. Spark-Gap Generated Coagulation Current.
3. A controlled mixed blend of both above currents on selection.
4. Mono-polar Oudin Desiccation-Fulguration Current.



Never before has a surgical unit of such performance been offered at the low price of the Blendtome.

Write "Blendtome Folder" on your prescription blank or clip your letter head to this advertisement. Reprint of electrosurgical technic mailed free on request. Please indicate your specialty.

**THE BIRTCHEE CORPORATION**  
5087 Huntington Drive Los Angeles 32, Calif.

Territorial Agent

**HOTEL IMPORT COMPANY**

HONOLULU, T. H.

## "Home" Specialists

are available  
for advice  
concerning  
personal . . .  
professional . . .  
or mercantile  
insurance  
protection.

Ask for a  
survey of *your*  
*insurable hazards*  
and the most  
economical way to  
guard against  
crippling financial loss!

**HOME**  **INSURANCE CO.  
OF HAWAII, LTD.**  
HOME INSURANCE BLDG. 129 S. KING ST. HONOLULU, HAWAII, U. S. A.

KING ST., BETWEEN FORT AND BISHOP

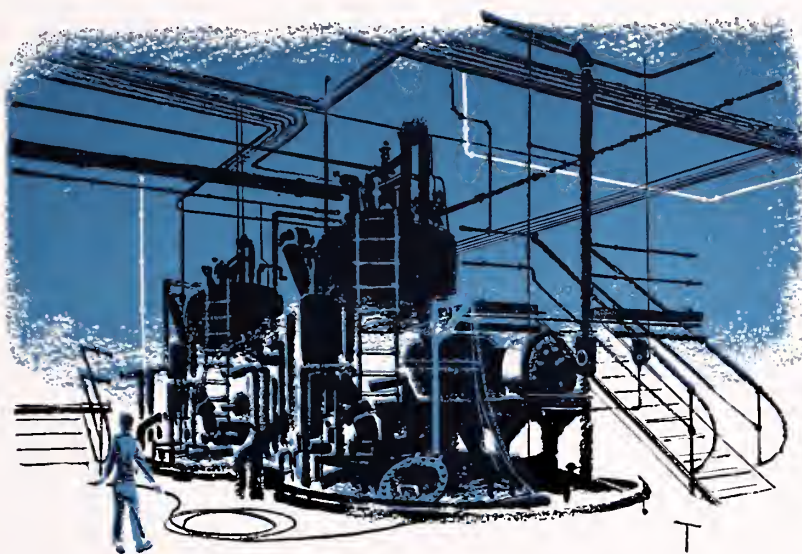
TELEPHONE 6-3521



# AUREOMYCIN

*Lederle*

*Effective against many bacterial and rickettsial infections, as well as certain protozoal and large viral diseases.*



The isolation of crystalline aureomycin from the fermentation mash is an intricate task. It must be done in such a way that inactivation or loss of the antibiotic is minimized. In addition, the removal of impurities must be so complete that the finished product will cause a minimum of undesirable side-reactions. For this purpose, highly specialized technical equipment is employed, in order to effect liquid-solid and liquid-liquid extractions. Vacuum concentration and crystallization

are carried out in glass-lined tanks, to avoid heavy metal contamination. The temperature and degree of vacuum are automatically controlled by means of precision instruments and the purification of the product is carefully followed by laboratory tests.

Aureomycin is now available in a number of convenient forms, for use by mouth and in the eye. New forms of this antibiotic of unsurpassed versatility are constantly being brought out.

*Capsules: Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.*

*Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.*

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N.Y.



**FOR RESERVATIONS  
IN HONOLULU  
Telephone 90-0355**  
Outrigger Arcade  
Kalakaua Ave., Waikiki  
Hono is now just 75 minutes by air  
from Honolulu

**HOTEL** *Hana-Maui*

Where there is all the fun in the world to enjoy  
And all the time in the world to do nothing.

Spacious Garden Pool • Deep Sea and Shore Fishing • Scenery and Folklore • Surfing, Swimming, Sunning  
at Beautiful Hono Beach, the envy of the islands • 9-hole Pitch-'n'-Putt Golf • Tennis • Cocktail Lounges •  
Gun and Spear Room

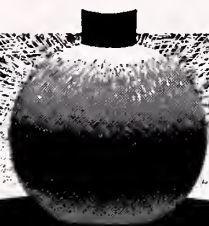


## INDEX TO ADVERTISERS

	PAGE		PAGE
Abbott Laboratories .....	223	Lederle Laboratories .....	22
American Factors .....	168	McArthur & Summers .....	Inse
Ar-Ex Cosmetics, Inc. ....	222	Mead Johnson & Co. ....	22
Ayerst, McKenna & Harrison, Ltd. ....	162	Merck & Company, Inc. ....	16
Birtcher Corporation .....	224	Parke, Davis & Company .....	158, 15
Borden Company .....	172	Pet Milk Company .....	21
Carnation Co. ....	217	Pfizer & Co., Inc. ....	220, 22
Dairymen's Association, Ltd. ....	170	Philip Morris & Co., Ltd., Inc. ....	16
Don Baxter, Inc. ....	227	Schering Corporation .....	16
Eli Lilly & Co. ....	157, Insert	Schuman Carriage Co., Ltd. ....	16
Hawaii Medical Service Association .....	206	Searle & Co. ....	21
Home Insurance Co. ....	224	Sharp & Dohme .....	16
Hotel Hana-Maui .....	226	Wander Company .....	16
Hotel Import Co. ....	218	Winthrop-Stearns, Inc. ....	16
International Travel Service .....	222	Wyeth Incorporated .....	169, 21



THE REAL DANGER IN  
**POTASSIUM  
DEFICIENCY**  
IS LACK OF  
EARLY RECOGNITION

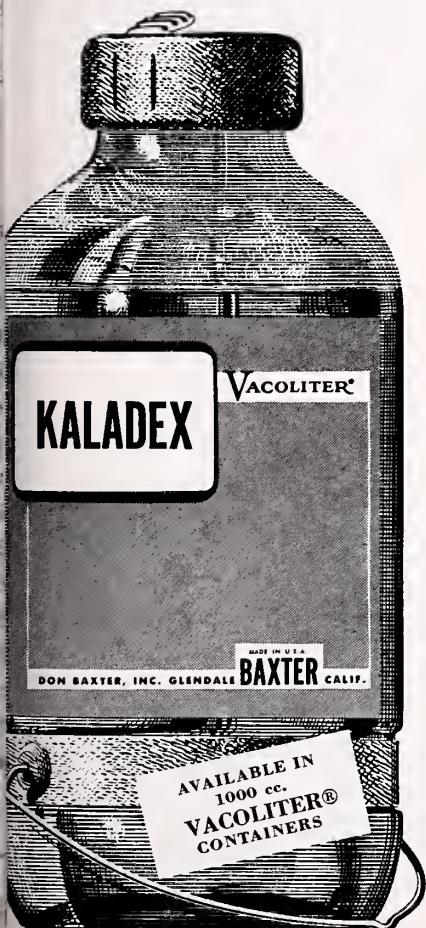


Know the causes . . . look for the symptoms and signs . . .  
treat promptly with

**KALADEX**

(Baxter 0.2% Potassium Chloride in 5% Dextrose Solution)

*Write for free abstract of the literature on  
potassium deficiency*



**DON BAXTER, INC.** • RESEARCH AND PRODUCTION LABORATORIES  
GLENDALE 1, CALIFORNIA

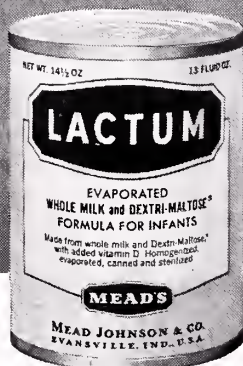
Editorial Distributor CROCKETT SALES COMPANY • P. O. Box 3017 • Phone 6-8992 • Honolulu, Hawaii



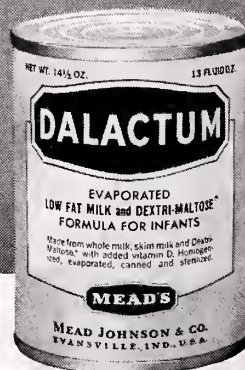
*Convenient... Simple to prepare... Nutritionally sound... Generous in protein*

**MEAD'S**

2 *new*



evaporated milk  
and  
Dextri-Maltose  
formulas



Infant feeding formulas of cow's milk, water and Dextri-Maltose\* have been prescribed for almost four decades, by two generations of physicians.

LACTUM and DALACTUM bring new convenience to such formulas. They are prepared for use simply by adding water. A one-to-one dilution supplies 20 calories per fluid ounce and is suitable for most infants.

LACTUM is a whole milk formula designed for full term infants with normal nutritional requirements.

DALACTUM is a low fat formula for both premature and full term infants with poor fat tolerance.

\*T. M. Reg. U. S. Pat. Off.

**MEAD'S**

MEAD JOHNSON & CO.  
EVANSVILLE 21, IND., U.S.A.



# HAWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

THE UNIVERSITY  
OF MEDICINE

APR 16 1951

LIBRARY

IE 10

MARCH-APRIL, 1951

NUMBER 4



PROLAPSING REDUNDANT GASTRIC MUCOSA Peter J. Washko.....	267
BLOOD CHANGES IN PREGNANCY Hugh G. Hamilton and Robert S. Higgins.....	274
LABORATORY DATA IN RENAL DISEASE A. V. Molyneux and Morton E. Berk.....	279
VENOUS THROMBOSIS AND PULMONARY EMBOLISM Rogers Lee Hill.....	283
FEATURES .....	285
INTER-ISLAND NURSES' BULLETIN .....	301

## REMEMBER THIS TERM?

*Balmar* 

Undoubtedly you would  
if you had practiced medicine in 1876, when homespun garments  
and tin tubs were giving way to "store clothes,"  
early modern plumbing, and health spas—  
and *Eli Lilly and Company* had just been founded.

Since then, the prescription for *Balneum maris*,  
meaning *sea-water bath*, has nearly vanished.

Today, you don't whip out a quill pen, write *Bal. mar.*,  
and send your patient packing to a distant spa  
or shore—for healing waters. Instead, you simply say,  
"Take a vacation"; or if medication is indicated,  
you may specify a Lilly product and thereby bring  
the latest benefits of pharmaceutical progress to his very door.



*Lilly*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

Primary Atypical Pneumonia

**you know what it is...** pure crystalline  
antibiotic of known chemical structure

Acute Undulant Fever

**you know what it does...**

produces rapid response

in a wide range of infectious diseases

Pertussis

Lymphogranuloma Venereum

**Chloromycetin**<sup>®</sup>

Chloramphenicol, Parke-Davis

Supplied in Kapseals<sup>®</sup> of 250 mg.,  
and in capsules of 50 mg.

Typhoid Fever

**PARKE, DAVIS & COMPANY**



Urinary Tract Infections

Herpes Zoster

Dysentery  
(shigella)

Rocky Mountain Spotted Fever

Bacterial Pneumonia



Scrub Typhus

Typhus Fever

Enteric Fever  
(salmonella)

Granuloma Inguinale





## All Children Can Benefit from *this Hot Drink at Breakfast*

The problem of encouraging children to eat an adequate breakfast finds easier solution when Ovaltine in hot milk is recommended as a breakfast beverage. Many children clamor for a hot drink at the morning meal and Hot Ovaltine is the right kind of drink to recommend.

A cup of Hot Ovaltine makes an excellent contribution of virtually all essential nutrients, adding substantially to the nutritional start for the day. It also serves in a gustatory capacity by enhancing the appeal of breakfast and making other foods more inviting.

The nutrient contribution made by a cup of Ovaltine is apparent from the table below. Note the wealth of essentials added to the nutritional intake by making the simple recommendation of adding a cup of Hot Ovaltine to the child's breakfast.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILLINOIS



### *Ovaltine*

Here are the nutrients that a cupful of hot Ovaltine, made of  
½ oz. of Ovaltine and 8 fl. oz. of whole milk,\* provides:

PROTEIN . . . . .	10.5 Gm.	IRON . . . . .	4 mg.	NIACIN . . . . .	2.3 mg.
FAT . . . . .	10.5 Gm.	COPPER . . . . .	0.2 mg.	VITAMIN C . . . . .	10 mg.
CARBOHYDRATE . . . . .	22 Gm.	VITAMIN A . . . . .	1000 I. U.	VITAMIN D . . . . .	140 I. U.
CALCIUM . . . . .	370 mg.	VITAMIN B <sub>1</sub> . . . . .	0.39 mg.	CALORIES . . . . .	225
PHOSPHORUS . . . . .	315 mg.	RIBOFLAVIN . . . . .	0.7 mg.		

\*Based on average reported values for milk.





the advantages of

**SULAMYD<sup>®</sup>**

(sulfacetimide)

**in  
prophylaxis  
and therapy  
of**

**urinary tract  
infections**

**high**

{  
pathogen specificity  
antibacterial activity  
urinary concentration  
urinary solubility

**low**

{  
systemic toxicity  
renal risk

dosage: Therapeutic—2 tablets (1 Gm.) t.i.d.  
Prophylactic—1 tablet (0.5 Gm.) t.i.d.

*Schering*

CORPORATION • BLOOMFIELD, NEW JERSEY

**S  
U  
L  
A  
M  
Y  
D**



## GROWING INDUSTRIES FOR A GROWING COMMUNITY



A new orchard starts: grafted tree is set out in the field.



Grafts of new varieties are made in the nursery.



Seedlings are started in nursery, grafted, then moved into orchard.



Orchard is laid out on lava flow; trees begin bearing in five years.

# MACADAMIA

## ...a hard nut to crack

*Hawaii today is exploring new industries to aid in expanding island economy—to bring in more money, create new jobs, provide permanent economic security. This series of advertisements will call attention to these forward steps and to their promise for Hawaii's future.*

It's taken more than twenty years and several million dollars to crack the hardest nut in the world... Hawaii's macadamia... and the problem's not completely cracked yet.

It's still the world's most expensive nut... still a rarity on Mainland food counters where the greatest market lies.

But experts in both agriculture and business, seeking new ways to expand local industry and seeing a great new expansion in macadamia nut production, look today to the tender little kernel with the tough cover to plug a big hole in Hawaii's economy.

Cautious businessmen and agricultural scientists now agree that macadamia nuts may be a million dollar industry and Hawaii's third large export crop.

And both businessmen and scientists have backed their predictions with the tools to make them true... the scientists, by providing new and outstanding varieties to produce larger yields of better quality; the businessmen, by providing the capital to bring large-scale production.

Already macadamia nuts are big business. And already growers look forward to creating a market demand larger than their own expanding orchards can supply. They point now to possibilities of profitable plantings by additional growers.

The macadamia story is a striking example of community teamwork... of University of Hawaii researchers who experimented on trees for ten years, of businessmen who invested in an industry that offers no return for at least a decade, of farmers who are putting the research results and the dollars to work.

It's the kind of teamwork that means a sounder future for all Hawaii... that builds growing industries to match a growing community.

### FREE BOOKLET



A brief survey of macadamia nut production—backyard and orchard—has been prepared as an aid to prospective growers. For a copy of the free folder, write The Hawaiian Electric Co., Ltd., P. O. Box 2750.

*The development of new industries requires individual initiative and community cooperation. In keeping with this progressive spirit of growth, The Hawaiian Electric Co., Ltd., is constantly planning ahead, expanding its own facilities and equipment... building today for tomorrow's needs.*

**THE HAWAIIAN ELECTRIC CO., LTD.**



**BUILDING TODAY for Tomorrow's Needs**



# NORM

Normal schedule of development (auxodrome) plotted on Wetzel Grid.<sup>1</sup>

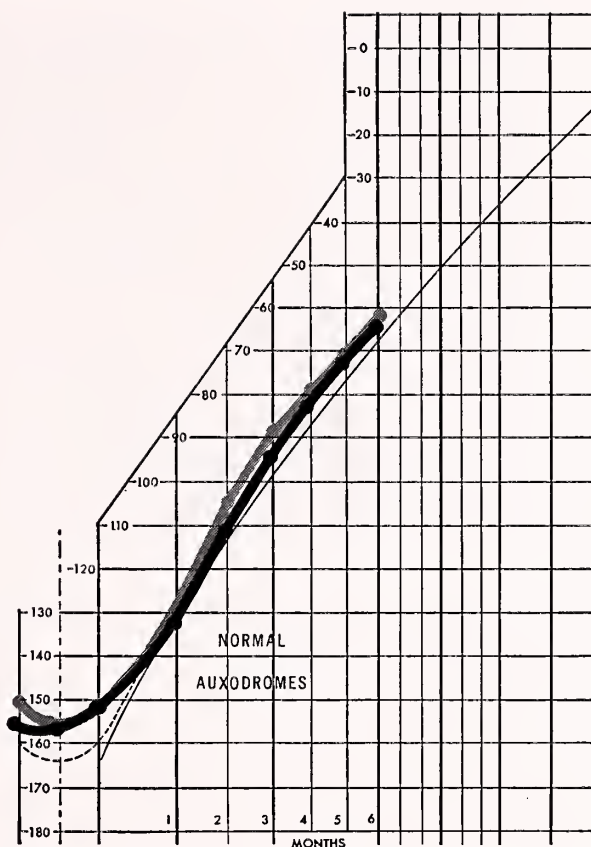
# CURVE A

Composite Wetzel Grid auxodrome of 60 unselected infants on S-M-A from birth to 6 months of age.

# CURVE B

Growth data, recomputed on Wetzel Grid, based on "selected subjects, most of whom were favored by environment,"<sup>2</sup> age: from birth to 6 months.

1. Wetzel, N. C.: J. Pediat. 29:439, 1946.
2. Jackson, R. L., and Kelly, H. G.: J. Pediat. 27:215, 1945.



*Comparative development rates prove...*

# S-M-A<sup>®</sup>

*builds husky babies*

Recent clinical studies of development rates of *unselected* S-M-A-fed babies (curve A on chart) prove its value. The growth results compare favorably with "standards which are considered to approach the optimum for general pediatric practice."<sup>2</sup> (curve B on chart).

*Because it is patterned after human milk*

# S-M-A<sup>®</sup>

*with Vitamin C added  
is recognized as an outstanding food for babies.*



Wyeth Incorporated, Philadelphia 2, Pa.





## has such remarkable qualities of DIGESTIBILITY

*And Aids in the digestion and absorption  
of other foods.*

Doan and Dizike of the University of Pennsylvania have made extensive study of the digestibility of various types of milk and cultured milk. They have established that such types of cultured milk are much easier to digest than ordinary milk.

It has been repeatedly established that Yami Yogurt can be taken daily by many children and adults who are allergic to milk. The curd tension of Yami Yogurt is zero.

During the preparation of Yogurt, the proteins of the milk undergo a profound bio-chemical change. This greatly affects the digestibility. In addition, Yogurt is very rich in diastases. This not only speeds its digestion, but helps in the digestion and absorption of other foods.

**yami**  
TRADE MARK REG.  
**yogurt**

A Yogurt is only as good, as stable, as potent, as healthful, as the culture from which it is made.

Yami Yogurt is the only Yogurt made from the original world-famous Rossell Institute culture.

Flown to Hawaii weekly, it is produced and distributed exclusively in Hawaii by Dairymen's Association, Ltd.

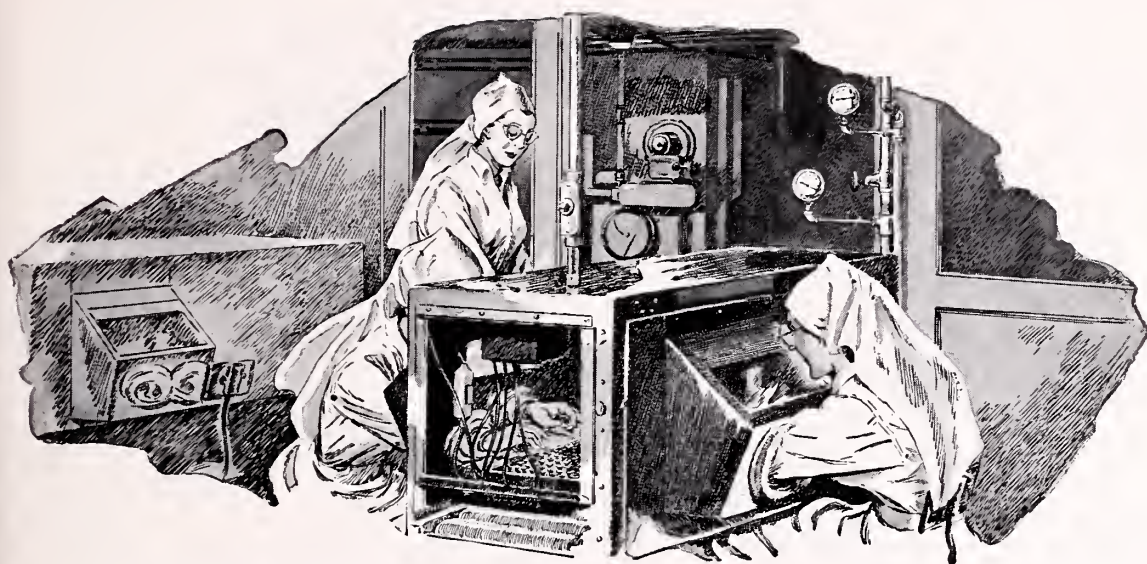
**AVAILABLE AT FOOD STORES**  
Or For Home Delivery, by

**Dairymen's**

**ASSOCIATION, LTD.**

A Division of Creameries of America, Inc.





# AUREOMYCIN

*Lederle*

*Hydrochloride Crystalline*

*Effective against many bacterial and rickettsial infections,  
as well as certain protozoal and large viral diseases*

Every precaution against contamination and every device that will safeguard the quality and sterility of the content of aureomycin in vials for research parenteral use has been adopted in the sterile filling rooms at our Pearl River laboratories. Rigid aseptic technique surrounds the filling process. The actual filling takes place in a stainless steel tunnel equipped with ultraviolet lights. No human hand

takes part at any stage, until the plugs are inserted in the vials. Plugging is done inside an ultraviolet irradiated chamber with only the sterile-gloved hand of the operator inside.

Aureomycin is now available in a number of convenient forms, for use locally and by mouth. New forms of this antibiotic of unsurpassed versatility are constantly being perfected.

Capsules: Bottles of 25, 50 mg. each capsule. Bottles of 16, 250 mg. each capsule.  
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* 30 Rockefeller Plaza, New York 20, N. Y.



**Going by Air?**

Whether you're heading for Oslo or Oshkosh—anywhere on any airline—Davies' air travel specialists can help you get there . . . help plan the trip, make the reservations, obtain the tickets. Davies is an authorized agent for scheduled airlines around the world, and for all hotels and connecting transportation. Your arrangements will be as easy and fast as your flight if you leave the details to Davies.

Air Division, Travel Department

**THEO. H. DAVIES & CO.**

Bishop & Merchant Sts.

Telephone 56991

*A phone call will bring our representative*





The liking for salt—and plenty of it—is particularly common to Americans.

**"The average American diet contains a daily intake of 6 to 15 Gm. of salt... And the effective, true low sodium diet will possess less than 2 Gm."**

When sodium restriction must be imposed, the desired "salty tang" can be given to foodstuffs with

## NEOCURTASAL®

*Salt without Sodium*

"Most patients favor this product."<sup>2</sup> Neocurtasal imparts a crisp flavor to vegetables, eggs and other foods—encouraging the patient to continue on a low sodium diet.

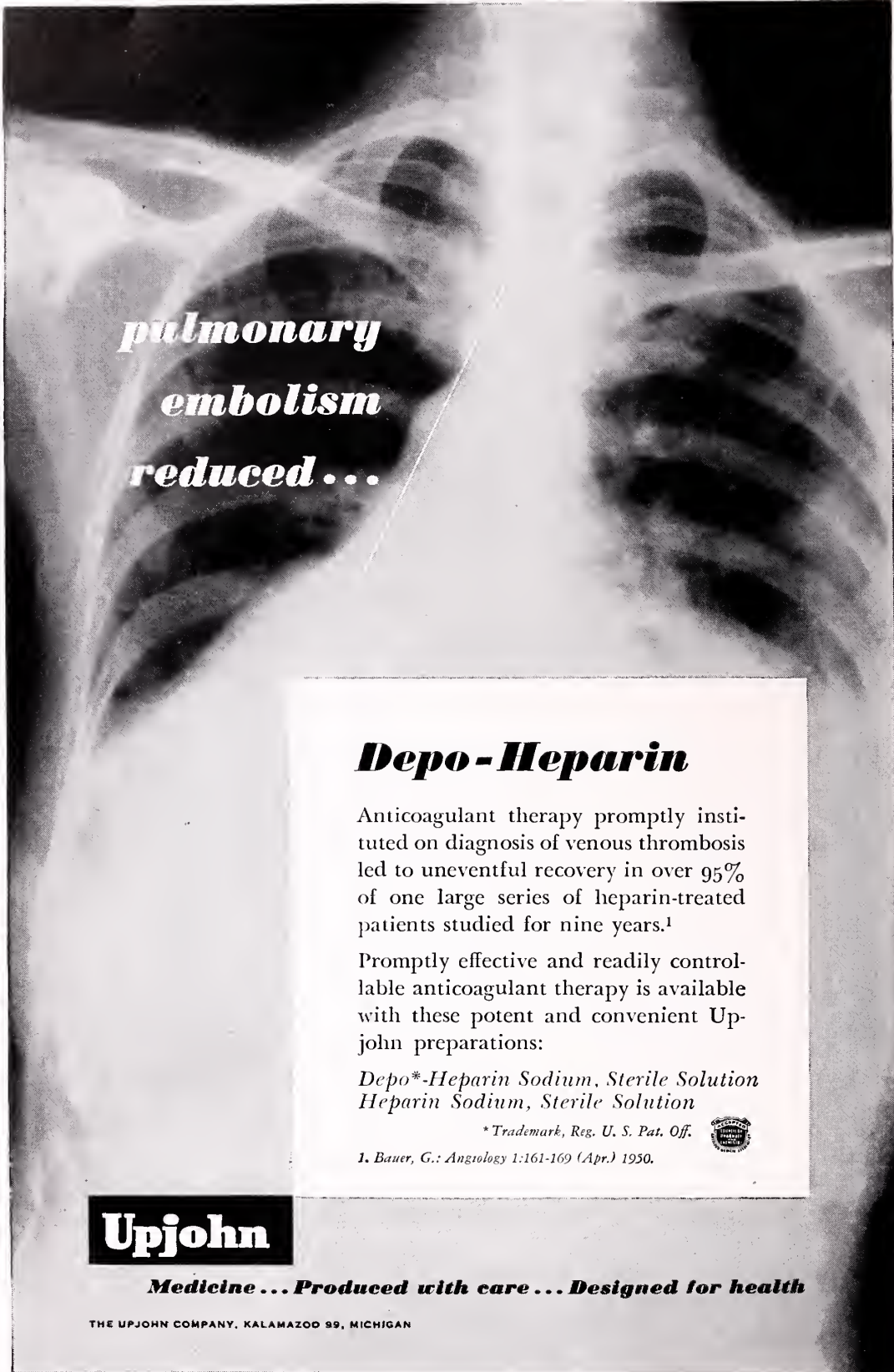
Neocurtasal is a completely sodium free seasoning agent, which looks and is used like ordinary table salt.

**CONSTITUENTS:** Potassium chloride, ammonium chloride, potassium formate, calcium formate, magnesium citrate and starch. Potassium content 36%; chloride 39.3%; calcium 0.3%; magnesium 0.2%

Available in convenient 2 oz. shakers and 8 oz. bottles.

*Write for pad of Low Sodium Diet Sheets.*

*Winthrop-Stearns* INC.  
NEW YORK 18, N. Y. WINDSOR, ONT.



***pulmonary  
embolism  
reduced...***

### ***Depo-Heparin***

Anticoagulant therapy promptly instituted on diagnosis of venous thrombosis led to uneventful recovery in over 95% of one large series of heparin-treated patients studied for nine years.<sup>1</sup>

Promptly effective and readily controllable anticoagulant therapy is available with these potent and convenient Upjohn preparations:

*Depo\*-Heparin Sodium, Sterile Solution*  
*Heparin Sodium, Sterile Solution*

\*Trademark, Reg. U. S. Pat. Off.



1. Bauer, G.: *Angiology* 1:161-169 (Apr.) 1950.

**Upjohn**

***Medicine... Produced with care... Designed for health***

THE UPJOHN COMPANY, KALAMAZOO 99, MICHIGAN



# When You Consider the High Cost of Babies . . .



**Favored Form of  
Milk for  
Infant Formula**



As a thoughtful physician, you know the expense of raising a baby is a serious matter to most young parents. You know that they are *grateful for advice* that helps them provide their baby with the best possible food at the lowest possible cost.

That's why so many doctors everywhere are recommending Pet Evaporated Milk for infant feeding! Pet Milk *does* assure babies of optimal nutrition . . . *does* give parents the benefits of maximal economy!

You know that easy-to-digest Pet Milk is uniformly rich in *all* the food values the best milk can be depended upon to supply! You know that it is surely safe . . . because Pet Milk is sterilized in its sealed container!

*Yet Pet Milk, the original evaporated milk, costs far less than special infant feeding preparations!*

So recommend Pet Milk for the babies in your care! It's nutritious! It's safe! And it keeps the cost down, too!

**PET MILK CO., 1424-C Arcade Bldg., St. Louis 1, Mo.**

THE PERFECT  
PROFESSIONAL CAR:

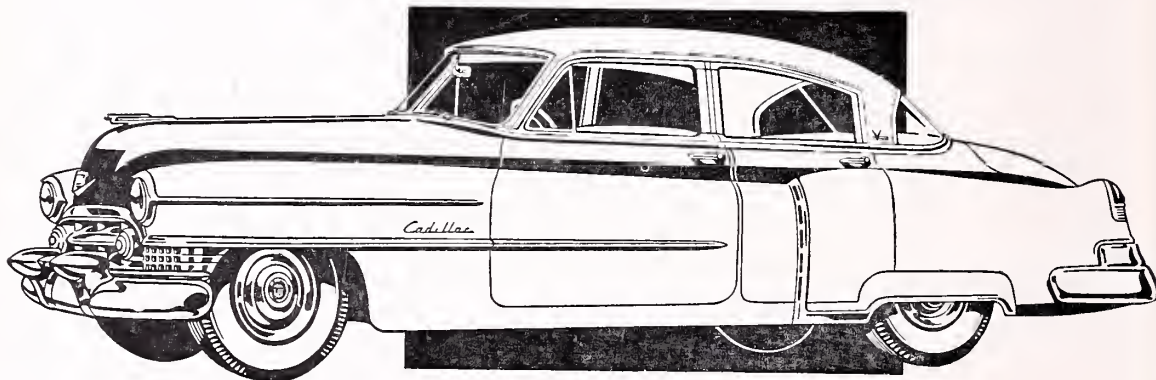
—  
■  
■  
■  
■  
■  
■  
■  
■  
■  
■  
—

*Cadillac*

Time proven endurance and dependability

There is new steadiness on the road . . . better balance on turns and curves . . . easier and softer braking. And throughout are vital improvements which add comfort and convenience.

All in all . . . the 1951 CADILLAC sets a new and higher standard for the automotive world. Stop in and see this wonderful car at Schuman Carriage Company.



Your personal inspection anytime at  
your convenience is invited.



**SCHUMAN CARRIAGE COMPANY**

Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU



**The "estrogen  
preferred by us is  
'Premarin,' a mixture  
of conjugated estrogens,  
the principal one  
of which is  
estrone sulfate."**

Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

In treating the menopausal syndrome with "Premarin," Perloff\* reports that "Ninety-five and eight tenths per cent of patients treated with 3.75 mg. or less daily obtained complete relief of symptoms"; also, "General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Thus, the sense of "well-being" usually imparted represents a "plus" in "Premarin" therapy which not only gratifies the patient but is conducive to a highly satisfactory patient-doctor relationship.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).



\*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

**"PREMARIN"®**

"Premarin" contains estrone sulfate plus the sulfates of equilin, equilenin,  $\beta$ -estradiol, and  $\beta$ -dihydroequilenin. Other  $\alpha$ - and  $\beta$ -estrogenic "diols" are also present in varying amounts as water-soluble conjugates.

*Estrogenic Substances (water-soluble) also known as Conjugated Estrogens (equine)*

**Ayerst, McKenna & Harrison Limited**  
22 East 40th Street, New York 16, N. Y.





## CLAY-ADAMS COMPANY, INC.

### LABORATORY SUPPLIES

Centrifuges

Museum Jars

Clinical Apparatus

OB Manikins

Microscope Supplies

Anatomy Charts, Atlases

Dissecting Kits

Chase Hospital Dolls

Surgical and Dissecting Instruments

Skeletons, Skulls

Orthopedic Instruments

Kodachrome Supplies

Diagnostic Supplies

Kodachrome Lantern Slides

Surgical Rubber Goods



*Territorial Agents*

## HOTEL IMPORT COMPANY

*Wholesale Druggists and Hospital Purveyors*

A Division of

VON HAMM-YOUNG COMPANY

Cooke and Kawaiahao Sts.



Honolulu

Phone 6-3561



# HAWAII MEDICAL JOURNAL

and

## INTER-ISLAND NURSES' BULLETIN

Volume 10  
Number 4

MARCH-APRIL, 1951

\$2.00 per Year  
35c per Copy

Published Bi-Monthly by

THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

### THE HAWAII TERRITORIAL MEDICAL ASSOCIATION

1950-1951

#### OFFICERS

R. L. HILL, Honolulu.....	President
HARRY L. ARNOLD, JR., Honolulu.....	President-Elect
LEO BERNSTEIN, Hilo.....	Vice-President from Hawaii County
S. L. YEE, Honolulu.....	Vice-President from Honolulu County
WILLIAM GOODHUE, Elelee.....	Vice-President from Kauai County
R. F. COLE, Paia.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

#### COMMITTEE CHAIRMEN

GROVER A. BATTEN.....	{ Cancer Committee
SAMUEL D. ALLISON.....	{ Resolutions Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	Health Education Committee
WILLIAM H. STEVENS.....	HAWAII MEDICAL JOURNAL
SAMUEL L. YEE.....	Committee on Psychiatry and Neurology
THOMAS H. RICHERT.....	By-Laws Committee
RICHARD C. DURANT.....	Advisory Board for Woman's Auxiliary
HARRY L. ARNOLD, JR.....	Public Service Committee
LAURENCE M. WIIG.....	Committee on Public Policy and Legislation
VERNE C. WAITE.....	Scientific Works Committee
ROBERT D. MILLARD.....	Postgraduate Committee
	Fee Schedule Committee

#### OFFICERS—COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....L. Bernstein, Hilo	S. L. Yee	W. Goodhue, Elelee	R. F. Cole, Paia
<i>Vice-President</i> .....T. D. Woo, Pepeekeo	J. W. Devereux	K. K. Fujii, Kapaa	E. Kushi, Wailuku
<i>Secretary</i> .....P. Okumoto, Hilo	W. Walsh	K. Kuhlman, Koloa	E. T. Shimokawa, Lahaina
<i>Treasurer</i> .....M. L. Chang, Hilo	W. Ito	K. Kuhlman, Koloa	E. T. Shimokawa, Lahaina

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1951, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second-class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.

## A Firm Foundation for a Sound Future

The first few months of life are of critical importance in building a healthy foundation for the infant. It is during this period that the demands for protein to create new tissue are greatest. And it is at this time that infants must have a food which supplies, in addition to adequate protein, other elements needed for sound growth. DRYCO feedings (with added carbohydrate) closely approximate the nutritional and digestive characteristics of human milk.

The DRYCO formula, in addition to a high-protein content, offers a reduced fat level. With added carbohydrate, DRYCO feedings assure sufficient caloric intake for normal requirements, while at the same time minimizing digestive disturbances.

Additional advantages of DRYCO are adequate vitamin and mineral potencies, moderate carbohydrate to provide formula flexibility, uniformity and bacteriological safety, as well as ease of preparation for the mother.



**VITAMIN  
FORTIFIED**

# **DRYCO**

*Detailed professional data, together with feeding tables may be obtained simply by writing to:*  
**THE BORDEN COMPANY, Export Division**  
350 Madison Avenue, New York 17, N. Y., U. S. A.



# Prolapsing Redundant Gastric Mucosa

PETER J. WASHKO, M.D.

HONOLULU

**P**ROLAPSE of redundant folds of the gastric mucous membrane into the duodenum has been the subject of relatively few reports in the medical literature, but it occurs frequently enough so that it should be recognized and reported and its clinical significance evaluated. As it becomes more widely recognized and the roentgenologic and gastroscopic criteria for diagnosis more firmly established, it appears that this condition is not at all rare, as shown by our experience here.



DR. WASHKO

## History

The first case of prolapse of gastric mucosa through the pyloric canal was reported by Von Schmieden<sup>1</sup> in 1911. The condition, however, was not recognized in this country until 1925, when Eliason and Wright<sup>2</sup> called attention to it and reported a case. In addition to the case reported by Von Schmieden in 1911, a review of the literature shows that Eliason and Wright<sup>2</sup> reported 1 case in 1925; Eliason, Pendergrass and Wright<sup>3</sup>, 2 cases in 1926; Shifflett<sup>4</sup>, 1 case in 1932; K. A. Meyer and Singer<sup>5</sup>, 1 case in 1935; W. H. Meyer<sup>6</sup>,

1 case in 1935; Pendergrass and Andrews<sup>7</sup>, 3 cases in 1935; Rees<sup>8</sup>, 4 cases in 1937; Bohrer and Copleman<sup>9</sup>, 1 case in 1938; Archer and Cooper<sup>10</sup>, 4 cases in 1939; Rubin<sup>11</sup>, 1 case in 1942; Melamid and Hiller<sup>12</sup>, 1 case in 1943; Mackenzie, MacLeod and Bouchard<sup>13</sup>, 2 cases in 1946; Cove and Curphey<sup>14</sup>, 22 cases in 1949; Scott<sup>15</sup>, 14 cases in 1946; and Harris and Byrne<sup>16</sup>, 30 cases in 1950. These last two series of cases were in groups of young men in large Naval hospitals.

## Incidence

In our experience, a prolapse of redundant folds of gastric mucosa occurs more frequently than is generally recognized. This is so because: (1) the filling defect and irregularity produced by the prolapse is often confused with that due to duodenal ulcer or duodenitis, or hypertrophy of the pyloric muscle, as described by Kirklin and Harris<sup>16</sup>; (2) the examiner may not be thinking about the condition; and (3) when recognized, it is sometimes considered of no significance and not mentioned. It is important that the roentgenologist make every effort to find this disorder, to distinguish it from duodenal ulcer and other conditions, and to report its presence to the referring physician.

During the last two and one-half years, in a

<sup>7</sup> Pendergrass, E. P., and Andrews, J. R.: Prolapsing Lesions of the Gastric Mucosa, *Am. J. Roent. and Radium Therapy* 34:337 (Sept.) 1935.

<sup>8</sup> Rees, C. E.: Prolapse of the Gastric Mucosa Through the Pylorus: Surgical Treatment, *Surg., Gynec., & Obst.* 64:689 (Mar.) 1937.

<sup>9</sup> Bohrer, J. V., and Copleman, B.: Prolapsing Redundant Gastric Mucosa, *Radiology* 31:220 (Aug.) 1938.

<sup>10</sup> Archer, V. W., and Cooper, G., Jr.: Prolapse of the Gastric Mucosa, *South. M. J.* 32:252 (Mar.) 1939.

<sup>11</sup> Rubin, J. S.: Prolapse of Polypoid Gastric Mucosa into the Duodenum with Malignant Change, *Radiology* 38:362 (Mar.) 1942.

<sup>12</sup> Melamid, A., and Hiller, R. I.: Prolapsed Gastric Mucosa: Roentgenologic Demonstration of Ulcer Crater in Prolapsed Polypoid Mucosa, *Am. J. Dig. Dis.* 10:93 (Mar.) 1943.

<sup>13</sup> Mackenzie, W. C., MacLeod, J. W., and Bouchard, J. L.: Trans-Pyloric Prolapse of Redundant Gastric Mucosal Folds, *Canad. M. A. J.* 54:553 (Jun.) 1946.

<sup>14</sup> Scott, W. G.: Radiographic Diagnosis of Prolapsed Redundant Gastric Mucosa into the Duodenum, with Remarks on the Clinical Significance and Treatment, *Radiology* 46:547 (Jun.) 1946.

<sup>15</sup> Harris, F. C., and Byrne, E. T.: Extrusion of Redundant Gastric Mucosa into the Duodenum, *U. S. Armed Forces Med. J.* 1:12 (Jan.) 1950.

<sup>16</sup> Kirklin, B. R., and Harris, M. T.: Hypertrophy of the Pyloric Muscle of Adults: A Distinctive Roentgenologic Sign, *Am. J. Roent. & Radium Therapy* 29:437 (Apr.) 1933.

<sup>17</sup> Cove, A. M., and Curphey, W. C.: Prolapse of Redundant Gastric Mucosa, *Surg., Gynec., & Obst.* 88:108 (Jan.) 1949.

Read before the Honolulu County Medical Society, October 6, 1950. From the Department of Roentgenology of The Clinic. Received for publication November 6, 1950.

<sup>1</sup> Von Schmieden, V.: quoted by Meyer and Singer.<sup>5</sup>

<sup>2</sup> Eliason, E. L., and Wright, V. W. M.: Benign Tumors of the Stomach, *Surg., Gynec., & Obst.* 41:461 (Oct.) 1925.

<sup>3</sup> Eliason, E. L., Pendergrass, E. P., and Wright, V. W. M.: The Roentgen Ray Diagnosis of Pedunculated Growths and Gastric Mucosa Prolapsing Through the Pylorus; Review of the Literature, *Am. J. Roent. & Radium Therapy* 15:295 (Apr.) 1926.

<sup>4</sup> Shifflett, E. L.: Tumors of the Duodenum and Hypertrophic Gastric Mucosa Prolapsing Through the Pyloric Canal into the Duodenum, *Radiology* 19:79 (Aug.) 1932.

<sup>5</sup> Meyer, K. A., and Singer, H. A.: Intermittent Gastric Ileus due to Mechanical Causes, *Surg., Gynec., & Obst.* 53:742 (Dec.) 1931.

<sup>6</sup> Meyer, W. H.: The Importance of Roentgen Gastric Functional Study in the Differential Diagnosis of Pyloric Lesions, *Radiology* 24:206 (Feb.) 1935.

series of approximately 3800 radiographic examinations of the upper gastrointestinal tract, 42 cases of prolapsed redundant gastric mucosa were found and reported. Five of these have been confirmed and corrected by surgery. The remainder responded to a medical regimen of bland diet, antacids, antispasmodics, etc.

### Etiology

The underlying etiologic factor or factors producing prolapse of the gastric mucosa into the duodenum are not known. Several interesting theories have been advanced. Eliason<sup>2</sup> in 1925 postulated that chronic irritation of the gastric mucosa resulted in chronic inflammation and hypertrophy of the mucosa. These hypertrophied folds are increased mechanically by the peristaltic contractions of the stomach. Eventually they become so elongated and redundant that they prolapse through the pyloric canal into the duodenum with the formation in some cases of single or multiple polyps of the prolapsed gastric mucosa. Pendergrass<sup>7</sup> thinks that anything productive of chronic gastritis may give rise to the condition. He has observed the greatest incidence in over-eaters and chronic alcoholics. He also suggests that duodenal stasis caused by congenital bands at the ligament of Treitz might give rise to the condition. Neither of these theories is fully supported by our studies. In none of the operative cases was there any roentgenologic, operative or pathologic evidence of gastritis. Rees<sup>8</sup> believes that narrowing of the pyloric canal precedes any change in the gastric mucosa and that this pyloric narrowing is followed by hyperperistalsis. This increase in stomach action causes loosening of the muscularis mucosa and in turn hypertrophy and prolapse. Organic changes of this nature were found in our Case 3. The development of gastritis in these cases is considered secondary by Rees. Moersch and Weir<sup>17</sup> believe that prolapse of the gastric mucosa is a manifestation of a developmental anomaly, for similar alterations are encountered elsewhere in the gastrointestinal tract. They believe as Rees<sup>8</sup> does that the gastritis which occurs in association with the prolapsed mucosa is a secondary process. The role of emotional factors, as emphasized by Scott<sup>14</sup>, may be an etiologic factor in the production of redundant mucosa. We know that emotions such as worry, fear, excitement and anger alter gastric function. The excess use of coffee, tobacco, and alcohol is known to disrupt gastric function. Scott<sup>14</sup> feels that in view of the construction of the stomach

walls, which normally permits a degree of mobility between them, it seems possible that certain neurogenic factors are the inciting cause of a disturbed gastric function which ultimately brings about a mucosal prolapse. It is interesting in his report that of 126 stomachs examined at autopsy for evidence of excessive mobility of the mucosa or a prolapse, in only one case was it possible to pull gastric mucosa with surgical forceps through the pyloric sphincter into the duodenum to simulate a prolapse. It is probable that psychosomatic factors play a role in all these cases.

### Diagnosis

There is no characteristic clinical syndrome or symptom complex that will permit a definite clinical diagnosis of this condition. The symptoms will vary with the degree of prolapse and the presence or absence of spasm, ulceration or obstructive factors. The diagnosis is made on the roentgenologic findings and by ruling out other gastrointestinal diseases. The symptoms are variable and include upper abdominal or epigastric discomfort, excessive gas, regurgitation, nausea and vomiting, burning pain, belching, bloating, heartburn, and occasional bleeding. The symptoms most closely resemble, and are often indistinguishable from, those found in patients with peptic ulcer, duodenitis or gastritis. A feeling of fullness after eating only a small amount of food is a common symptom. The discomfort is often relieved by small amounts of food but seldom by alkalies, which may be a clue to the diagnosis and should be considered in patients with atypical peptic ulcer history. Melamed and Hiller<sup>12</sup> reported a case of profuse intestinal bleeding with resultant secondary anemia as the presenting complaint.

The gastric analysis is usually within normal limits. Serologic tests for syphilis are usually negative. Oral cholecystogram demonstrates a normally functioning gallbladder. The physical examination reveals no consistent abnormalities except for tenderness in the epigastrium on deep palpation in some patients. The disorder should also be suspected in those patients who do not make the usual response to an ulcer regimen, in those with recurrent functional complaints and in those with repeated recurrences when placed on solid foods.

The diagnosis of prolapsing redundant gastric mucosa is essentially made by fluoroscopic and radiographic examination but the condition can at times be suspected from the clinical history. The appearance at x-ray examination is quite characteristic but the presence of this lesion will often be overlooked unless this condition is kept in mind

<sup>17</sup> Moersch, H. J., and Weir, J. F.: Redundant Gastric Mucosa Simulating Carcinoma of the Stomach, *Am. J. of Dig. Dis.* 9:287 (Sept.) 1942.



at all times by the examiner. The filling defect due to prolapse of the gastric mucosa into the duodenal bulb is found at the base of the duodenal bulb immediately distal to the pyloric opening. Of course, the extent of the defect is determined by the amount of the prolapsed mucosa. We find a rather constant umbrella or mushroom deformity in the base of the duodenal cap as the most characteristic roentgenologic finding, with or without elongation and widening of the pyloric channel and increase in the size of the rugae of the pylorus and antrum. Rarely, if ever, do duodenal ulcers produce a filling defect of this character. The degree and extent of the prolapse may vary from time to time or it may even become completely reduced during an examination or at later examinations. The redundant gastric rugae can usually be traced from the antral canal through the pyloric canal into the base of the duodenal cap. The prolapsed folds appear as dark-white spaces between the thinner spaces of barium on either side.

With prolapse there are no signs of the ordinary duodenal ulcer, no irritability or spasm of the duodenal cap, and no ulcer craters, niches or incisurae, unless there is an associated ulceration of the redundant mucosal folds. Gastric peristalsis is usually more active and vigorous in these patients than in the average person.

Other pathologic conditions that must be differentiated from redundant prolapsed gastric mucosa include prolapsed pedunculated gastric tumors and polyps, benign pyloric hypertrophy, carcinoma of the pylorus, simple antral spasm, pyloric or prepyloric ulcers with periulcerative infiltration, myomas of the pylorus, gastric syphilis, secondary hypertrophic pyloritis associated with pyloric stenosis, and duodenitis. Tracey and Arnold<sup>18</sup> recently reported a prolapse of the gastric mucosa simulating carcinoma. There is often a six-hour residue of barium in the stomach due to this partial mechanical obstruction at the pylorus and duodenal base. The absence of a filling defect in the upright position and the presence of a defect in the prone position is of diagnostic importance. It can, however, be demonstrated in both positions.

### Treatment

Until only recently, reports in the literature have stressed the surgical treatment of prolapse of the gastric mucosa. This was based on the supposition that it would always be difficult to rule out with certainty the possibility of actual malignant disease or of lesions which might later be-

come malignant. However, with more definite roentgenologic criteria set up for this diagnosis, surgical exploration and treatment is becoming much less frequent and is now limited to those cases complicated by gastric retention and obstruction, ulceration with hemorrhage and anemia, severe pain, or failure to respond to a controlled medical regimen. In slight and in some moderate prolapses, frequent feedings, bland diet, antispasmodics, antacids, avoidance of emotional tension and the elimination of contributing etiologic factors such as smoking, alcoholism, chronic upper respiratory infections and dental caries will often bring relief of symptoms. Hospitalization with rest in bed, relaxation and sedation may be of value. Under this type of medical treatment, the frequently associated hypertrophic antral gastritis is often relieved and the necessity for surgery overcome. However, this strict medical regimen is often a great burden to the patient and also incompatible with an active life in certain types of individuals. In these, and in those who have complications or do not respond to medical treatment, surgery is certainly indicated.

We believe that surgical therapy should be reserved for those patients with considerable degrees of pyloric obstruction, polyp formation with suspected malignant degeneration, ulceration with recurrent severe hemorrhage not prevented by adequate medical therapy, severe anemia due to chronic blood loss, suspected malignancy, and failure to respond to medical therapy.

Rees<sup>8</sup> has reported an effective surgical technique based on a Fredet-Ramstedt principle. He uses a small longitudinal incision down to the mucosa with elevation and excision in an oblique line of the redundant mucosa leaving sufficient membrane to prevent stricture. Gastro-jejunostomy has been done by others but has often failed to relieve symptoms, for although it provides an unobstructive outlet for the stomach, it does not prevent a hypertrophic fold of mucosa from being swept through the pylorus. Partial gastrectomies have also been done but these are undoubtedly too radical a procedure for this benign condition.

The surgical procedure of choice now appears to be excision of the prolapsed redundant mucosal folds, with pyloroplasty. A pyloroplasty through a longitudinal incision, later closed transversely, with resection of the redundant mucosal folds, has a wider range of application, adds little to the risk and insures adequate functional result. Eliason<sup>3</sup> has emphasized several important points to be borne in mind when operating upon a patient in whom this lesion is suspected: (1) the stomach and duodenum should be palpated simultaneously

<sup>18</sup> Tracey, M. L., and Arnold, W. T.: Prolapse of the Gastric Mucosa Simulating Carcinoma, *Lahey Clinic Bul.* 6:244 (Apr.) 1950.

to avoid slipping away of the folds from the examiner's fingers through the pylorus, (2) the stomach should always be opened to rule out the presence of a redundant fold as well as other lesions that may not be palpable through the gastric wall.

tory laparotomy which was done on March 28, 1949 by Dr. J. E. Strode. Redundant gastric mucosa about the pylorus was found and a pyloroplasty with excision of redundant folds was done. She made an uneventful recovery and up to the present time has been completely free of gastrointestinal symptoms with improved generalized well being.

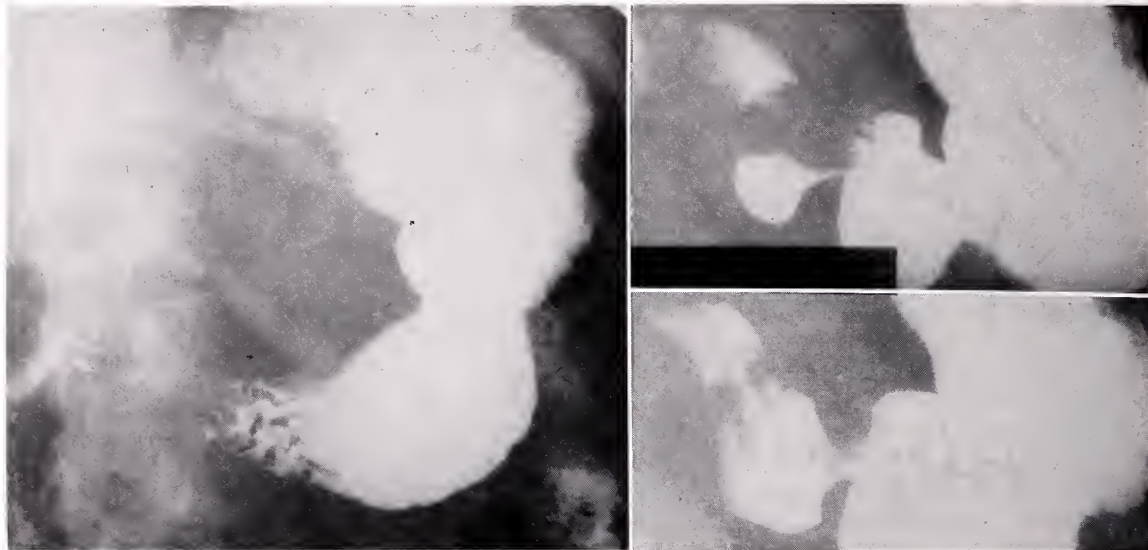


Fig. 1. (Case 1.) "Mushroom" or "Umbrella" defect in the base of the duodenal cap with pylorospasm and marked redundancy of the distal gastric mucosa. Note the normal contour of the duodenal cap except for the typical defect of the prolapsed mucosa at the base.

### Case Reports

**CASE 1.** I.M., a 35-year-old Portuguese nurse, was first seen on February 28, 1949. She complained of vague stomach trouble present recurrently since 15 or 16 years of age, with epigastric pain and vomiting which would last for about a week. She would be free of symptoms, sometimes for several years at a time. The most severe attack was in 1942, at which time she was confined to a hospital for two weeks. Occasionally this pain and discomfort was in the gallbladder area and at one time was referred around behind her lower right costal margin into her back. Cholecystogram studies in 1936 and 1942 showed a sluggish gallbladder with poor contraction but no evidence of stones. Recently she had had a good deal of gas and occasional vomiting. Pain had been severe enough on several occasions to require morphine hypodermically.

A gastrointestinal series recently done elsewhere was diagnosed as duodenal ulcer. Repeat cholecystogram study and upper G.I. series was done in March 1949. Cholecystogram study at this time showed a normally functioning gallbladder with good contraction and no evidence of stones. Upper gastrointestinal tract study on March 17, 1949 under fluoroscopy with barium and on subsequent films showed prolapsed redundant gastric mucosa with a mushroomlike deformity at the base of the duodenal cap. There was moderate secondary pylorospasm. The prolapse was sliding in type and reducible and showed no evidence of obstruction or of ulceration. Because of the long recurrent history and the recent severity of the symptoms she chose explora-

**CASE 2.** T.Z., a 31-year-old Caucasian woman, was first seen on August 22, 1949 complaining of vague upper abdominal pain and discomfort and symptoms of several years' duration, suggestive of duodenal ulcer. Roentgenographic examination on August 24, 1949 showed marked redundancy of the gastric mucosa about the antrum with prolapse through the pylorus, with secondary widening of the pyloric canal, and prolapse of the redundant folds into the base of the duodenal cap. No gastric or duodenal ulceration was found. Further questioning after this diagnosis revealed that her recurrent pain and discomfort were not relieved by medication of any kind. She often vomited and felt bloated and full and often had severe pain which was not relieved by anything except vomiting. She also had tarry stools on two occasions. Repeat study of the upper gastrointestinal tract was done on August 29, 1949 because of recent x-ray impression elsewhere of a malignant lesion in the distal third of the stomach. Surgery was advised and redundant prolapsed gastric mucosa was found with no evidence of malignancy or ulceration. A Finney pyloroplasty with excision of the redundant folds was done by Dr. R. G. Johnston. She has remained free of symptoms to the present time.

**CASE 3.** F.P., a 60-year-old Caucasian man, had a long and recurrent history of abdominal symptoms and discomfort. Pain and discomfort often relieved by self-induced vomiting. Pain sometimes came on an hour or two after eating and was relieved by citrocarbonate. Roentgenographic studies on several occasions previous



to this showed no evidence of ulcer or other organic disease except for pylorospasm. Diverticulosis of the colon had been diagnosed at one time. Patient stated that his trouble was worse when he got nervous or irritated and was becoming gradually worse as time went

on. Highly seasoned, rough and highly citrated foods and liquids caused more trouble. No significant loss of weight had occurred. General physical examination was essentially negative. Blood pressure was 110/80. Gastric analysis was normal. Cholecystogram study was nega-

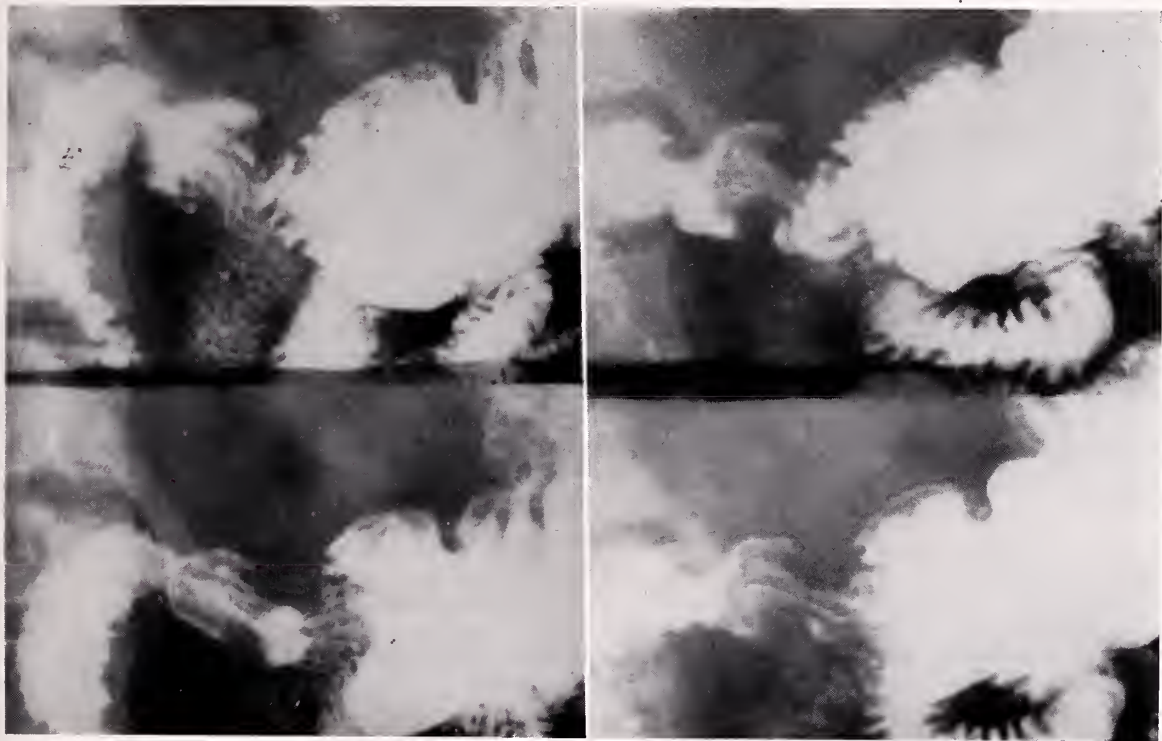


Fig. 2. (Case 2.) Marked typical defect of prolapsed mucosa in the base of the duodenal cap with widened pyloric canal and redundant gastric mucosa. The prolapsed mucosa is sliding in type and occupies almost the entire duodenal cap.

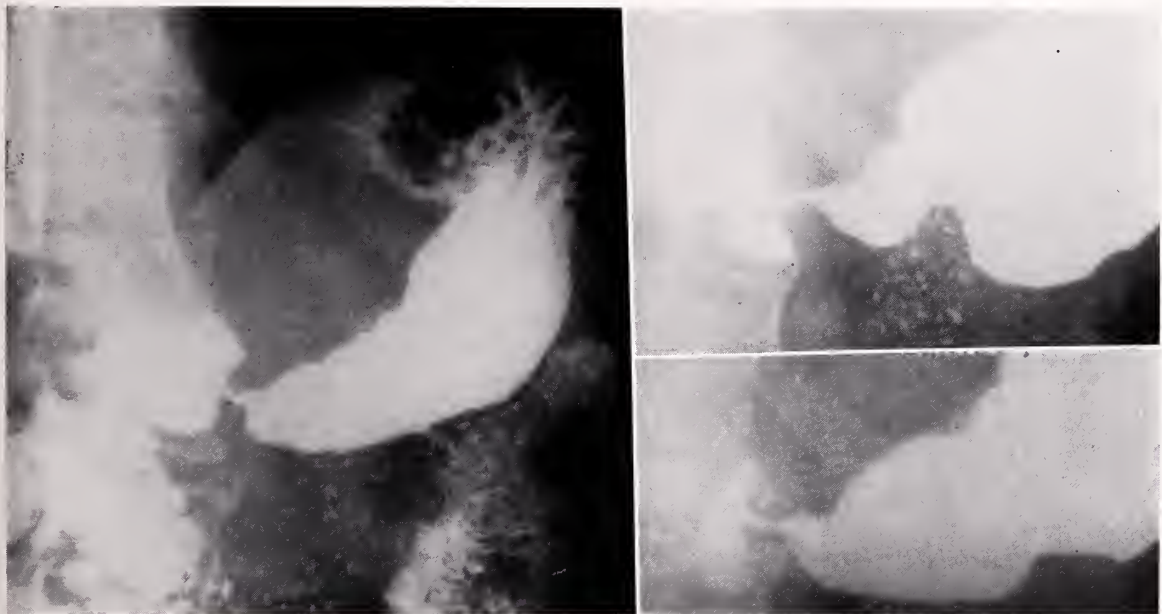


Fig. 3. (Case 3.) Films of 1943 and 1947 showing narrowed, elongated pyloric canal probably due to underlying old prepyloric ulcer with scarring and fibrosis. No evidence of redundant prolapsing gastric mucosa.

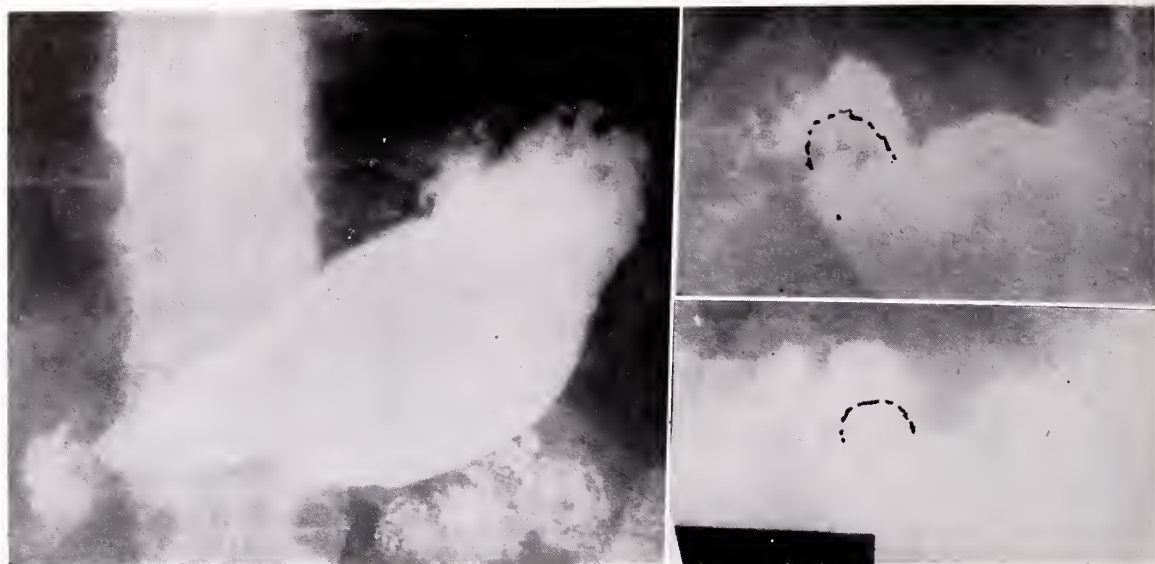


Fig. 4. (Case 3.) Study of September, 1949, showing redundant gastric mucosa with prolapse through the pylorus into the base of the duodenal cap.

tive. A roentgenographic upper gastrointestinal tract study done in 1943 was negative except for pylorospasm, and a narrowing and elongation of the pyloric canal. This scarring of the pylorus was felt to be secondary to an old pre-pyloric ulcer at this site.

There was no significant improvement under a medical regimen and several subsequent upper gastrointestinal tract studies here and on the mainland showed essentially the same narrowing and elongation of the pylorus, probably due to underlying fibrosis and scarring. However, in September 1949 a repeat examination of the upper gastrointestinal tract showed a redundant gastric mucosa with prolapse through the pylorus into the base of the duodenal cap at this time. It was felt by the roentgenologist that constant peristalsis against the previously reported narrow and elongated pylorus made the distal gastric mucosa loose and redundant with secondary widening of the pylorus and a prolapse of the redundant gastric mucosa into the base of the duodenal cap.

Because of the long history and lack of any significant response to medical therapy, exploratory laparotomy was advised by Dr. J. E. Strode and accepted. On opening and exploring the abdomen, no evidence of ulcer of the stomach or duodenum could be made out. There was a thickening of the pylorus which felt as though there was a worm-like mass in that area. The impression was that of hypertrophied pyloric muscle and gastric mucosa, with excess mucosa beneath. The other intra-abdominal viscera were negative. An incision made across the pylorus to the duodenum and on up into the stomach showed an excess of gastric mucosa. The pyloric muscle was greatly thickened. Excess mucosa was trimmed off and excised and the mucosa sutured together. The incision was then sutured side to side to give it an adequate pyloric outlet. Patient improved immediately after surgery and has remained well to the present time with no further gastrointestinal symptoms of any consequence.

CASE 4. H.P., a 38-year-old Caucasian woman, had been seen for a number of years with symptoms not referable to the gastrointestinal tract. In October of 1949 she was seen because of epigastric distress, tenderness on pressure, and gas for the past several weeks, unrelated to eating. This distress generally began about an hour after breakfast, but after other meals it usually came on within a few minutes. There was no nausea or vomiting, no history of constipation or diarrhea. She had had three operations for ovarian cysts. Physical examination was negative, and gastric analysis normal. Cholecystogram study on November 5, 1949 showed a normally functioning and normally outlined gallbladder with good contraction and no evidence of stones. Roentgenographic examination of the upper gastrointestinal tract on November 8, 1949 showed redundant gastric mucosa with prolapse through the pylorus into the base of the duodenal cap. No evidence of gastric or duodenal ulcerating lesion was seen, and the upper gastrointestinal tract was otherwise negative.

A medical regimen of bland diet, antispasmodics and sedation was advised but no symptomatic relief was obtained. Operation on February 3, 1950 by Dr. J. E. Strode showed adherence of the pyloric end of the stomach to the side of the gallbladder due either to adhesions or congenital bands. These were freed. The pylorus was found to be thickened and there was increased gastric peristalsis. An incision made over the duodenum and the pyloric end of the stomach, with exposure of the pylorus, showed prolapse of the gastric mucosa. It was very redundant and was easily lifted up and trimmed off. The incision was converted into a pyloroplasty. Exploration of the remainder of the abdomen showed no evidence of other organic disease. The pathologic report of the excised redundant mucosa showed edema and no evidence of gastritis. The patient improved and has remained well.



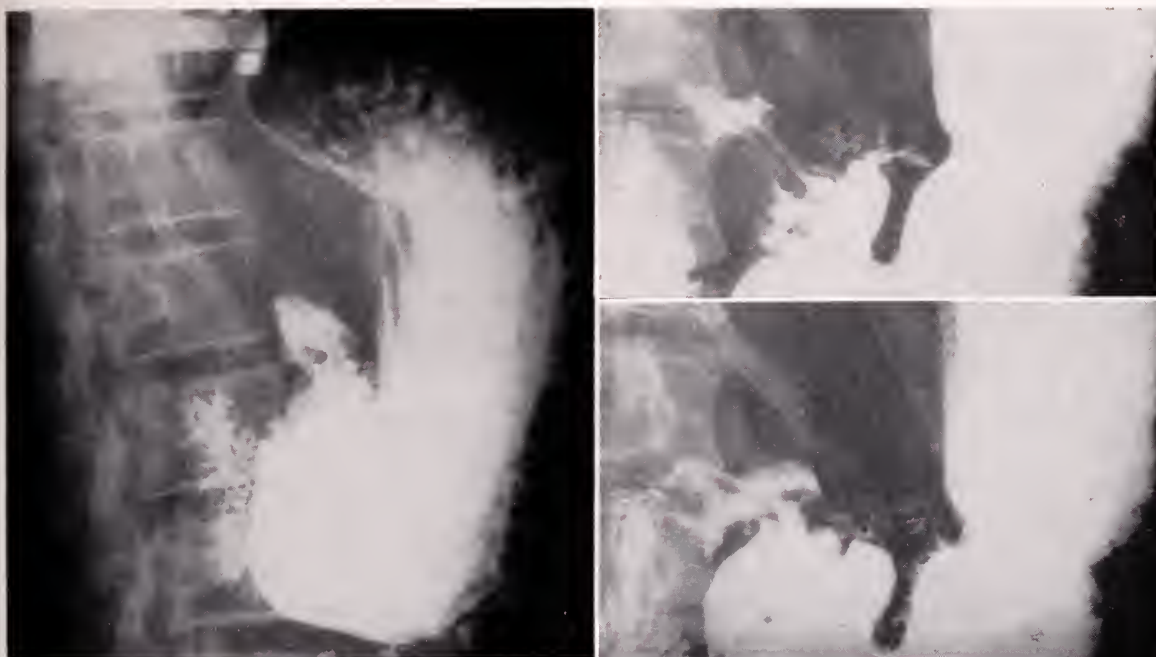


Fig. 5. (Case 4.) Large "mushroom" or "umbrella" defect in the base of the duodenal cap with widening of the pyloric canal and redundant distal gastric mucosa.

### Summary and Conclusions

1. Prolapse of redundant gastric mucosa through the pylorus is a distinct clinical entity. Four cases are reported, verified by surgery, out of a total of 42 in which the clinical and roentgenologic findings were considered consistent with this diagnosis.

2. The condition occurs more frequently than gastric ulcer. In approximately 3800 gastrointestinal examinations made at The Clinic during the past 2½ years 42 cases were found.

3. The diagnosis of prolapsed gastric mucosa is established mainly by the roentgen examination. No distinctive clinical syndrome was found, but symptoms referable to the upper gastrointestinal tract were present in all cases and suggest this diagnosis in those patients with atypical ulcer histories and in those who do not respond to an ulcer regimen.

4. The etiology is unknown but is probably a combination of organic and functional factors.

5. The pathologic change is an abnormal mobility and redundancy of the prepyloric mucosa with prolapse through the pylorus into the base of the duodenal cap.

6. The characteristic roentgenologic findings are a negative or cauliflower-like defect at the base of the duodenal cap, often associated with narrowing or widening and elongation of the pyloric canal, antral spasm, and large antral rugae.

7. Uncomplicated and mild cases of prolapsed gastric mucosa may respond to a medical regimen. Surgical treatment with excision of the redundant mucous membrane and pyloroplasty is indicated in those cases with complications such as ulceration, obstruction or recurrent hemorrhage, in those with anemia or polyp formation with malignant degeneration and suspected malignancy, and in those who do not respond to a medical regimen.

# Hematological and Serum Protein Changes Occurring in Uncomplicated Pregnancy

HUGH G. HAMILTON, M.D. AND ROBERT S. HIGGINS, M.D.

KANSAS CITY, MISSOURI

THESE STUDIES attempt to correlate the changes occurring in normal pregnancy in the hemoglobin content of the blood, the erythrocyte count, the leucocyte count, the hematocrit data and the fractional serum proteins.

The examinations were conducted on 411 consecutive patients, no selection being made except the exclusion of patients showing any pathologic state that might alter the normal course of the pregnancy. The age and parity factors are shown in Table 1.

TABLE 1.—*Age and Parity.*

	PRIMIPARA	MULTIPARA	TOTAL
Number of Patients	281	130	411
Age of Patients	23.3 yrs. Range 16-39	26.3 yrs. Range 16-43	24.2 yrs.

The laboratory methods used were all standard published technics for the erythrocyte, leucocyte and hematocrit determinations. The hemoglobin estimations were by the Haden-Hausser<sup>21</sup> technic. For the first one hundred determinations of the serum protein values, the Kjeldahl method was used along with the biurette technic of Weichselbaum<sup>48</sup>, running the Kjeldahl and biurette technic simultaneously on each individual. After it was clear that there was no variation in the results between the two technics, the more cumbersome Kjeldahl method was abandoned and the remainder of the series was completed using the Weichselbaum method.

All patients were advised at their first visit, with reiteration at subsequent visits, to eat ample protein, and any patient showing anemia was placed on anti-anemic therapy. How much this may have modified the results is questionable, as Odell shows little change in the serum proteins and Talso and Dieckmann<sup>46</sup> demonstrate small modification in the blood count by the methods we used.

## Historical Background

Stander and Tyler<sup>38</sup>, in 1920, first pointed out that the water content of blood increases up to the seventh month of gestation and then remains stationary or rises slightly until term. They show that the erythrocyte count and the water content vary inversely. Attention was first focused on the problem of the serum proteins in pregnancy by the work of Plass and Bogert<sup>32</sup> and Coetzee<sup>8</sup> in 1924. These workers found that there was a drop in serum proteins early in pregnancy, and a rise post-partum. Plass and Matthew<sup>33</sup>, pursuing the study further, showed a drop in the total protein from the onset of pregnancy to the last four weeks, with a rise almost to normal in the last four weeks. They showed also that the albumin fraction has a deeper curve of drop than does the total serum protein and is back almost to normal, but not quite, in two weeks post-partum. They say that the globulin shows little regular change. Eastman<sup>16</sup> demonstrated that there is a slight relative increase in globulin in the normal pregnancy and that the average A/G ratio is 1.7. Dieckmann and Wegner<sup>11</sup>, using a much larger series of cases than former authors, showed that there is a 6 per cent decrease in the protein concentration in pregnancy and 2 per cent more depletion in the first post-partum week, but that serum proteins return to their original value by the fifteenth post-partum day. They stated that while the volume percent decreases, there is an actual increase in the total amount of serum protein per kilogram of body weight when one excludes the weight of the fetus, placenta and amniotic fluid. Dodge and Frost<sup>15</sup> and Rheinhart<sup>34</sup>, in subsequent work, fully confirmed the previous findings of these authors.

Robinson and Hogden<sup>35</sup>, Kingsley<sup>24, 25</sup> and Weichselbaum<sup>48</sup> all give excellent methods for the determination of the serum proteins and albumin and globulin fractionation.

There are many discussions in the literature regarding the effect of hypoproteinemia and attendant edema in both pregnancy and non-pregnancy. Strauss<sup>40-44</sup> was one of the first to stress the importance of an adequate protein intake in the prevention of edema and toxemia. Myers and

Read before the Honolulu Obstetrical and Gynecological Society, August 21, 1950.

Received for publication September 15, 1950.



Taylor<sup>31</sup>, several years earlier, discussed the effects of hypoproteinemia as a result of the deficient utilization of proteins either by faulty ingestion or faulty metabolism. Others discussing the effect of hypoproteinemia upon edema are Binger and Keith<sup>6</sup>, Rytand<sup>36</sup> and Messinger.<sup>29</sup>

Cross<sup>9</sup>, in 1929, pointed out that liver function tests show the liver to be under stress during normal pregnancy, and that the stress becomes more intense as the pregnancy progresses, being progressive and greatest in the last trimester and during labor.

TABLE 2.—Hemoglobin, Range and Average Determinations.

	3 MOS. GESTATION	6 MOS. GESTATION	9 MOS. GESTATION	8 WEEKS POST PARTUM
Primipara	70% *54%-87%	69% *53%-84%	69% *55%-83%	75% *66%-90%
Multipara	71% *58%-90%	67% *52%-80%	69% *52%-83%	77% *67%-90%
Average	70%	68%	69%	76%

\* Range.

Bruckman and Peters<sup>7</sup> state that edema is present in patients with malnutrition only when the serum albumin is below normal, showing that with a serum albumin above 4 Gm. per cent they will rarely have edema, and that they invariably have edema if the serum albumin falls as low as 3 Gm. per cent.

Sullivan<sup>45</sup> *et al.* found a retention of bilirubin in bilirubin tests for liver function when the liver had been damaged by toxemic states, in what we would now interpret as a protein depleted liver. Herscheimer<sup>22</sup> makes similar observations in normal pregnancy based upon the hippuric acid excretion test. Dodd and Minot<sup>14</sup> demonstrate that there is a deficiency of serum protein in patients fed on diets which are low in total calories or proteins. Experimental work on animals by Madden<sup>27</sup> and his co-workers and by Weech<sup>47</sup> indicated that dietary hypoproteinemias can be developed and point out the relationship between edema and low serum albumin levels.

Madden and Whipple<sup>28</sup> show that the food proteins furnish the amino acids, and that when they are absorbed from the gastro-intestinal tract they are synthesized by the liver cells into the plasma proteins. They further demonstrate that in the absence of liver damage, the ability to build the plasma proteins and hemoglobin comes from the material stored in the liver. Elman<sup>18,19</sup> and his co-workers believe that in severe hypoproteinemias, unless the serum albumin is lowered to such a great extent that the body is unable to meet the depletion effect, the serum albumin rapidly cor-

rects and holds the plasma protein volume up to a level allowing the body to correct the loss. They suggest that the cause of death in these patients is too great a depletion of the albumin fraction. The work of Ebert<sup>17</sup> confirms these findings. Conversely, low protein diets produce liver damage, as well as liver damage being a factor in the production of hypoproteinemia. These facts are demonstrated by Beattie and Steele<sup>1</sup> and also by Gurogy.<sup>20</sup> Berryman and Bollman<sup>34</sup>, by producing experimental hepatitis in animals by restriction of diet, reduce the level of the proteins in the plasma mostly at the expense of the plasma albumin. They state that this reflects the functional capacity of the liver more than the dietary deficiency. In a subsequent article they contend that pregnancy causes a lowering of fraction which is reflected in the total serum protein level, and that the concentration of albumin is not markedly affected.

The liver feeding experiments of Whipple and Robscheit-Robbins<sup>49</sup> produced hypoproteinemias with concomitant reduction of protein storage, showing storage of only one-half to one-third of the normal amount of hemoglobin-producing factors in the liver. Their experiments further demonstrate that the important reserve stores for hemoglobin building are in part protein and are jealously guarded by the body even in the face of severe bleeding. The protein intake must be lowered also to lower the storage of the protein fraction of the hemoglobin-producing store. They also found that the values for hemoglobin production in the livers of eclamptic and lactating women are very low, owing in the former to the depletion of the disease, and in the latter to the drain on the body economy by lactation.

TABLE 3.—Erythrocyte Count,† Range and Average Determinations.

	3 MOS. GESTATION	6 MOS. GESTATION	9 MOS. GESTATION	8 WEEKS POST PARTUM
Primipara	3,67 *2,28-4,74	3,61 *2,72-4,80	3,65 *2,50-4,52	3,92 *3,05-4,84
Multipara	3,74 *2,97-4,94	3,53 *2,58-4,16	3,70 *2,89-4,40	3,96 *2,98-4,90
Average	3,69	3,65	3,67	3,94

\* Range. † Final four zeros omitted.

Bibs<sup>5</sup>, in his studies, observed that hypoproteinemia was a constant finding in hyperemesis gravidarum and in the late toxemias, and indicated that some women on adequate diets go into hypoproteinemia and toxemia even though the diet be completely adequate. He found no correlation between serum protein and hemoglobin levels, nor between anemia and toxemia.

Stead and Ebert<sup>39</sup> proved that exercise causes a decrease in plasma volume and an increase in hematocrit, hemoglobin and serum protein in both normal and splenectomized humans. The same effect is obtained by epinephrine administration. They conclude that, although the spleen acts as a blood reservoir in the dog, cat and horse, it does not do so in the human.

TABLE 4.—*Leucocyte Count, Range and Average Determinations.*

	3 MOS. GESTATION	6 MOS. GESTATION	9 MOS. GESTATION	8 WEEKS POST PARTUM
Primipara	8,282	9,184	8,673	7,519
Range	4,750-12,900	4,500-17,800	3,100-17,300	3,850-11,550
Multipara	8,250	8,477	8,582	7,368
Range	5,200-11,700	5,500-12,800	5,050-14,500	4,850-10,800
Average	8,190	8,830	8,627	7,443

Miller and Whipple<sup>30</sup> show the protective effect of methionine and cystine (sulphur-containing amino-acids) in the protection of the liver in protein depletion states. They emphasize the necessity, therefore, of a high protein and amino-acid intake in the diet as well as a high carbohydrate diet in liver protection. Macarthur's<sup>26</sup> recent cases emphasize the use of methionine, as a sulphur-containing amino-acid, in the protection of the liver in the toxemic states of pregnancy. Seeley<sup>37</sup> demonstrated that in protein-depleted animals the feeding of beef protein stimulated albumin production, that casein stimulated both albumin and globulin production, whereas casein hydrolysates (amigen) stimulated only globulin formation.

### Results

With the foregoing facts in mind, it would appear that these statistics should differ from the normal findings in untreated pregnancy, because the latter patients were all supposed to be on high protein diets, and all were on standard anti-anemic therapy. However, these women, in spite of ap-

proved therapy, still show typical curves for pregnancy when one plots the hemoglobin, the erythrocyte count, the leucocyte count, the hematocrit and total serum proteins with their fractions and ratio. This, then, should emphasize to us the imperative necessity of adequate dietary and anti-anemic therapy in pregnancy.

TABLE 5.—*Hematocrit, Range and Average Determinations.*

	3 MOS. GESTATION	6 MOS. GESTATION	9 MOS. GESTATION	8 WEEKS POST PARTUM
Primipara	37 Range 26-46	36 Range 29-47	37 Range 29-55	41 Range 34-51
Multipara	38 Range 33-46	36 Range 31-57	37 Range 27-45	41 Range 35-46
Average	37	36	37	41

In analyzing our results, it was found that in each series of work the hemoglobin, the erythrocyte count, the leucocyte count, the hematocrit, the total serum protein, the serum albumin, the serum globulin and the A/G ratio values for the primipara and the multipara ran so closely parallel that their average figure was equivalent for each. Accordingly, we have plotted only the averages for the primipara and the multipara. The values found in the tables and charted in the figures demonstrate that there is a close parallelism between the hemoglobin, the erythrocyte count, the hematocrit and the total serum protein; i.e., all reveal an appreciable drop from three to six months, a slight rise from six to nine months and a rise above three months at 8 weeks post-partum. The leucocyte count acted in a reverse manner. The serum albumin shows a marked drop during the pregnancy and a complete return following pregnancy. In contradistinction to the findings of other authors, except Eastman<sup>16</sup>, our serum globulin figures show a consistent rise throughout the pregnancy and an additional rise in the post-partum period. The albumin-globulin ratio, to a large extent, duplicates the serum albumin curve.

TABLE 6.—*Total and Fractional Serum Proteins, Average and Range Determinations.*

	TOTAL SERUM PROTEINS				SERUM ALBUMIN				SERUM GLOBULIN				A/G RATIO			
	3 Mos. Gest.	6 Mos. Gest.	9 Mos. Gest.	8 Wks. P.P.	3 Mos. Gest.	6 Mos. Gest.	9 Mos. Gest.	8 Wks. P.P.	3 Mos. Gest.	6 Mos. Gest.	9 Mos. Gest.	8 Wks. P.P.	3 Mos. Gest.	6 Mos. Gest.	9 Mos. Gest.	8 Wks. P.P.
Primipara																
Average	6.97	6.96	6.91	7.20	4.52	4.39	4.40	4.58	2.45	2.57	2.51	2.62	1.84	1.76	1.77	1.84
Range	6.08 8.00	5.58 7.78	6.08 7.65	6.57 7.86	3.81 5.09	3.20 4.98	3.75 5.13	4.23 5.07	2.27 2.91	2.38 2.80	2.33 2.52	2.34 2.79	1.09 2.69	1.34 2.18	1.32 2.19	1.54 2.23
Multipara																
Average	6.98	6.83	6.89	7.23	4.58	4.42	4.37	4.61	2.40	2.41	2.52	2.62	1.87	1.88	1.70	1.81
Range	6.08 7.69	5.99 7.82	6.05 7.65	6.33 8.14	4.27 5.12	3.96 5.26	3.93 4.78	4.21 4.84	1.81 2.55	2.03 2.56	2.12 2.87	2.12 3.30	1.47 2.69	1.44 2.28	1.46 2.14	1.34 2.38
Average	6.97	6.89	6.90	7.21	4.55	4.40	4.39	4.59	2.42	2.49	2.51	2.62	1.85	1.82	1.73	1.82



Discussion

It is our feeling that this series of cases is of sufficient number to make the findings statistically sound. In many of the early series the numbers of cases, as shown by Dieckmann, are sufficiently small to explain the differences between their findings and these figures.

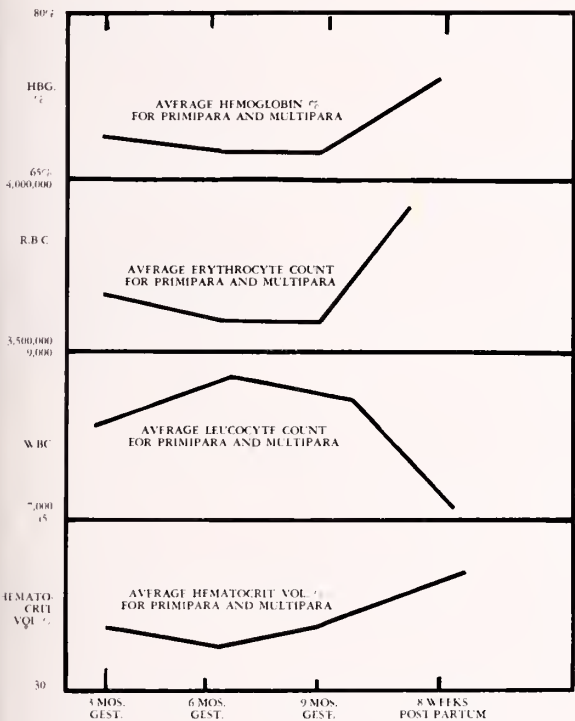


FIGURE I

It was felt that the demonstration of reduction in serum albumin, associated with the globulin rise, makes it clear why the experimental work on liver damage in protein depletion states is germane to this study. If the work of Sullivan, Herscheimer, Elman and others, which shows the toxic effects of serum albumin depletion upon the liver, is accepted, then these figures, which show a lowered serum albumin with a concomitant elevated globulin, would indicate the importance of prophylactic dietary control of pregnant women. In consideration of dietary control one should not lose sight of the work of Seeley. This would teach us to feed patients beef products, with casein as a second choice, and to avoid casein hydrolysates which metabolically yield globulin. In the event of the failure of control by dietary methods, methionine medication as used by Macarthur would be sound.

Furthermore, the liver feeding experiments of Whipple, which show the reduction in hepatic storage of the hemoglobin-producing factor in

serum protein (and especially serum albumin) depletion serve to explain, in company with the hydration effect of Stander and Tyler, the allegedly physiologic anemia of pregnancy. Likewise, these facts, plus the increase in total blood volume in pregnancy, help to explain the therapeutic difficulties involved in the treatment of the anemias of pregnancy.

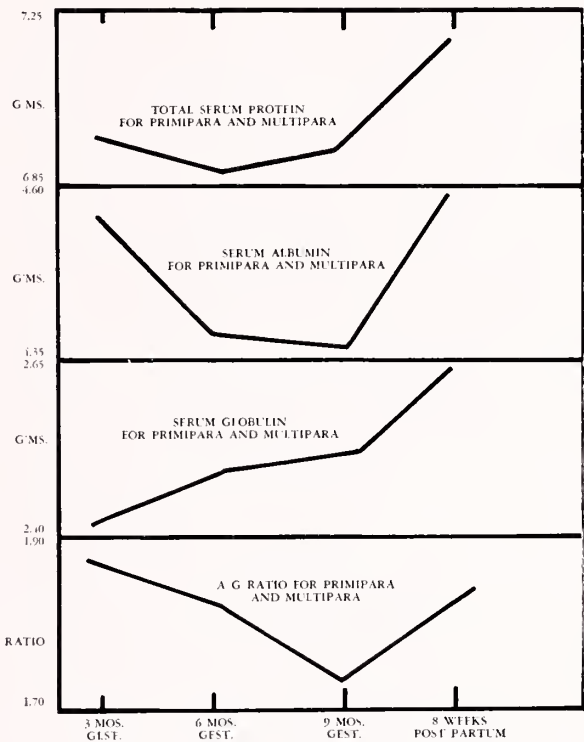


FIGURE II

Summary and Conclusions

Hemoglobin, erythrocyte count, leucocyte count, hematocrit, total serum protein and protein fraction determinations were made at 3 months, 6 months, 9 months and 8 weeks post-partum on 411 cases.

The average value for serum globulin was found to show a steady rise during pregnancy and into the post-partum period.

During the pregnancy the average values for the total serum proteins fell slightly and steadily until the later part of the pregnancy and then showed a post-partum rise to normal. This drop was entirely at the expense of the serum albumin fraction.

The curves for the hemoglobin, the total serum protein, the erythrocyte count and the hematocrit were found to be almost identical.

The so-called physiologic, or more properly

idiopathic, leucocytosis of pregnancy was demonstrated.

The A/G ratio curve was found to approximate the curve of the serum albumin.

1102 Grand Avenue

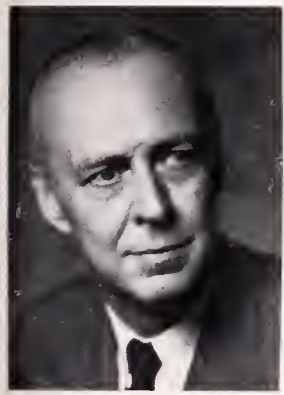
### Bibliography

1. Beattie, J., Herbert, P. H. and Steele, C. W.: *Brit. M. J.* 1:209, 1944.
2. Beck, A. C.: *Obs. Prac.*, Baltimore, 1942, Williams and Wilkins.
3. Berryman, G. H. and Bollman, J. L.: *Am. J. Physiol.* 139:592, 1943.
4. Berryman, G. H. and Bollman, J. L.: *Am. J. Physiol.* 139:596, 1943.
5. Bibbs, J. D.: *Am. J. Obs. & Gyn.* 42:103, 1941.
6. Binger, M. W. and Keith, U. M.: *J.A.M.A.* 109:1, 1937.
7. Bruckman, F. S. and Peters, J. P.: *J. Clin. Invest.* 8:591, 1930.
8. Coetsee, L. J.: *Proc. Roy. Soc. Med.* 18:28, 1924.
9. Cross, R. C.: *Am. J. Obs. & Gyn.* 18:800, 1929.
10. Davis, C. H.: *Gynec. & Obst.* Hagerstown, Md., 1943, W. F. Prior, Vol. 1, p. 27.
11. Dieckman, W. J. and Wegner, C. R.: *Arch. Int. Med.* 53:353, 1934.
12. Dieckman, W. J.: *Toxemias of Preg.*, St. Louis 1941, C. V. Mosby 59-61.
13. DeLee, J. B., Greenhill, J. P.: *Prin. & Prac. of Obs.*, Phila., 1947, W. B. Saunders, 446-448.
14. Dodd, Katherine and Minot, A. S.: *J. Pediat.* 8:452, 1936.
15. Dodge, E. F. and Frost, T. T.: *J.A.M.A.* 3:898, 1938.
16. Eastman, N. J.: *Am. J. Obs. & Gyn.* 19:343, 1930.
17. Ebert, R. V., Stead, E. A. Jr., and Gibson, J. G.: *Arch. Int. Med.* 68:578-590, 1941.
18. Elman, R., Lischer, G. E.: *Int. Obst. Surg.* 76:503, 1943.
19. Elman, R., Lischer, G. E. and Davey, H. W.: *Am. J. Physiol.* 138:569-577, 1943.
20. Guorgy, P.: *Am. J. Clin. Path.* 14:67-86, 1944.
21. Haden, R. L.: *Prin. of Hematology*, Phila., 1947, Lea and Febiger, 86.
22. Herscheimer, A.: *Am. J. Obs. & Gyn.* 29:395, 1935.
23. Hyman, H. T.: *Integrated Prac. of Med.*, Phila., 1947, W. B. Saunders, Vol. 1, 592.
24. Kingsley, G. R.: *J. Biol. Chem.* 131:197, 1939.
25. Kingsley, G. R.: *J. Biol. Chem.* 133:731, 1940.
26. Macarthur, J. L.: *Am. J. Obs. & Gyn.* 55:382-395, 1948.
27. Madden, S. C., George, W. E., Warrich, G. S., and Whipple, G. H.: *Jour. Exp. Med.* 67:75, 1938.
28. Madden, S. C. and Whipple, C. A.: *Physiol. Rev.* 20:194-217, 1940.
29. Messinger, M. J.: *Can. M. A. J.* 55:381-393, 1946.
30. Miller, L. L., Whipple, G. H.: *Jour. Exp. Med.* 76:421, 1942.
31. Myers, W. K. and Taylor, F. H.: *J.A.M.A.* 101:198, 1933.
32. Plass, E. D. and Bogert, L. J.: *Bull. Johns Hopkins Hosp.* 35:361, 1924.
33. Plass, E. D. and Matthew, C. W.: *Am. J. Obs. & Gyn.* 12:346, 1926.
34. Rheinhardt, R. E.: *Am. J. Obs. & Gyn.* 50:48-55, 1945.
35. Robinson, H. W., Hogden, C. G.: *Jour. Biol. Chem.* 135:727, 1940.
36. Rytand, D. A.: *Arch. Int. Med.* 69:251, 1942.
37. Seeley, R. D.: *Am. Jour. Physiol.* 144:369-377, 1945.
38. Stander, H. J. and Tyler, M.: *Surg. Gyn. & Obs.* 31:276, 1920.
39. Stead, E. A., Jr. and Ebert, R. V.: *Am. J. Med. Sci.* 201:655, 1941.
40. Strauss, M. B.: *Am. J. Med. Sc.* 190:811, 1935.
41. Strauss, M. B.: *Am. J. Med. Sc.* 194:772, 1937.
42. Strauss, M. B.: *Am. J. Med. Sc.* 195:723, 1938.
43. Strauss, M. B.: *Am. J. Med. Sc.* 196:188, 1938.
44. Strauss, M. B.: *Am. J. Obs. & Gyn.* 38:199, 1939.
45. Sullivan, C. F., Tew, W. P. and Watson, E. M.: *Jour. Obs. & Gynaec. Brit. Emp.* 41:347, 1934.
46. Talso, P. J. and Dieckmann, W. J.: *Am. Jour. Obs. & Gyn.* 55:518, 1948.
47. Weech, A. A.: *Bull. N. Y. Acad. Med.* 15:63-91, 1939.
48. Weichselbaum, E. E.: *Am. J. Clin. Path., Tech. Sec.*, 10:40, 1946.
49. Whipple, G. H. and Robscheit-Robbins, F. S.: *Jour. Exp. Med.* 76:283, 1942.
50. Wintrobe, M. M.: *Clinical Hematology*, Phila., 1947, Lea & Febiger, 90-91.



# The Correlation of Laboratory Data With Renal Disease

A. V. MOLYNEUX, M.D. AND MORTON E. BERK, M.D.  
HONOLULU



DR. MOLYNEUX

**D**URING THE past few decades there have been many conflicting, often diametrically opposed ideas regarding the therapy of glomerulonephritis and other renal disease. The impact of Thomas Addis' work in this field has been more than casual. It was he who carefully conceived the idea of "resting" the

diseased kidney by maintaining a high urinary output and by giving the patient a diet with an adequate minimum of protein required for maintenance and growth and, to supplement this regimen, vitamins and calcium were added.<sup>1</sup> Dr. Addis formulated some simple technics he could utilize for diagnosing and following the progress of the patient's disease. All urines examined are timed, so that the approximate 24-hour excretory rate of substances in the sediment may be determined.<sup>1</sup>

It is the purpose of this paper to present some of the ways in which these laboratory procedures aid the physician in evaluating the status of renal disease. We would like to stress the fact that it is important for the physician to look at the urinary sediment so that he may have a complete picture of the disease from first-hand observation. For complete information on the actual techniques involved, and for a fascinating compilation of data pertaining to glomerulonephritis and other diseases of the kidney, Dr. Addis' book<sup>1</sup> is recommended.

### Case Presentations

**CASE 1.** E.V.B., a 21-year-old youth, was first seen by one of us (M.E.B.) in the Stanford University Renal Disease Clinic April 1949. Eight days previous to examination, he had developed malar edema during the day,

and by the next morning the edema had spread to include his ankles. Five days after onset he developed a severe pounding headache. About three weeks before onset he had had "flu" with high fever, chills and sore throat. This was treated with bed rest for three days. This young man had moved from Lucia, Italy, to San Francisco during May 1948.

**Past History.** In 1940, while afflicted with severe bronchitis, he developed glomerulonephritis. His physician examined his urine weekly and advised a diet which restricted meat, eggs, salt and wine (cheese was unavailable) for two months. His urine then became "clear" and his dietary restrictions were removed. His history was otherwise negative.

**Physical Examination.** The patient was a well developed, alert young man. There was a moderate amount of soft, pitting edema in the malar, peri-orbital and malleolar areas. His blood pressure was 156/94. The laboratory data are shown in Fig. 1. The presence of hypoproteinemia, proteinuria and rich urinary sediment, coupled with the history and clinical picture, was sufficient evidence for a diagnosis of degenerative nephritis.

**Therapy** consisted of a low protein diet estimated on the basis of 1/2 gram per kilo of body weight plus the amount of protein excreted in twenty-four hours. In addition the sodium intake was restricted to 1 gram daily, while high carbohydrate and liquid consumption was encouraged. One week later E.V.B.'s weight had dropped 13 1/2 pounds. His blood pressure was 120/75. Only a trace of the edema remained. We suspect that the excretion of 11.2 grams of sodium chloride (Fig. 1) was

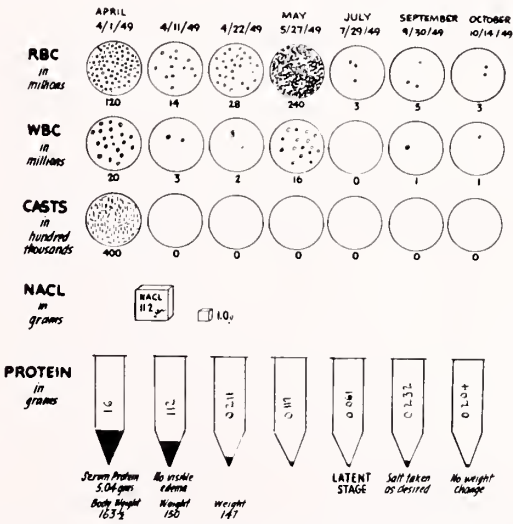


Fig. 1 - (Case 1) URINARY SEDIMENT AND PROTEINURIA IN 24 HRS

<sup>1</sup> Read before the 60th annual meeting, Hawaii Territorial Medical Association, Hilo, Hawaii, May 5, 1950.

From the Department of Internal Medicine of The Medical Group, Honolulu, T. H.

<sup>2</sup> Addis, T., Glomerular Nephritis, New York, The MacMillan Co., 1948.

due to a "washing-out effect." From this point on, the patient progressed rapidly. By the end of July he had definitely passed back into the latent stage. The addition of salt to his diet did not affect his now normal blood pressure, nor did it produce edema.

When his timed urine specimen shows less than 1 million red blood cells in twenty-four hours for several consecutive months, we may presume his kidneys are "healed."

CASE 2. P.S., a 12-year-old Caucasian youth, was seen in the office October 30, 1949. He had the classical triad of symptoms of acute glomerulonephritis: edema, hypertension and urinary findings. Two weeks previously he had what his mother described as impetigo.

He was put on a low protein, low salt diet supplemented by calcium and multiple vitamins. Because his blood pressure went up to an unusually high figure, 204/140, he was also given some magnesium sulfate. At the time of discharge from the hospital, November 19, his blood pressure was down to 114/70. His laboratory data are shown in Fig. 2. In this case, the clinical picture suggests, and the urinary findings confirm, the end of the acute episode. It is very important to watch the urines carefully during the latent stage of nephritis, because it is by careful, frequent observation of timed urines that the healing kidneys can be followed. As in the case of the patient from Italy, the criterion of healing will be the reduction of red blood cells in the urine to less than one million in twenty-four hours, and there should be a continued absence of other elements in the sediment.

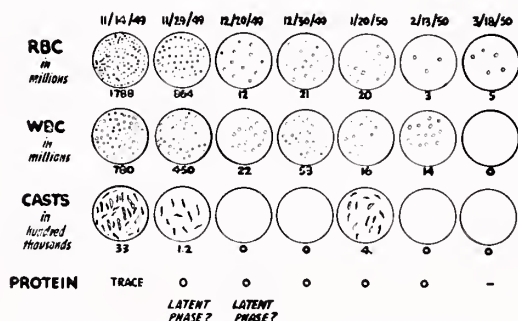


Fig 2 (Case 2) URINARY SEDIMENT (24 HOUR EXCRETORY RATE)

CASE 3. J.P. is a 43-year-old Caucasian man. From 1930 to 1949 there were few days when he did not consume at least one quart of whiskey. During this period he developed hypertension, his blood pressure frequently going up to 188/130. Concurrently his urine showed albumin and his blood showed mild nitrogen retention. Until 1947 bed rest and abstinence from alcohol invariably resulted in a return of his blood pressure and nitrogen level to normal. By 1944 there was evidence of irreversible renal damage. Urograms done in 1947 showed faintly outlined renal pelvis and evidence of poor renal function. Since 1947 his diastolic level has been over 105, and his urinary sediment has reflected various changes occurring in the kidney. Some idea of how poor his renal function is may be gained from noting that his urinary volume averages 35 cc. per 20 minutes.

In 1949 his NPN slowly climbed. When we first examined his urine his blood NPN was 83 mgm. per 100 cc. and the creatinine was 2.6 mgm. per 100 cc. Since his blood chlorides were normal and since he was not edematous, we advised a diet containing 45 grams of protein and 5 grams of salt. (The latter was to prevent further nitrogenous retention.) His counts and blood chemistries are shown in Fig. 3.

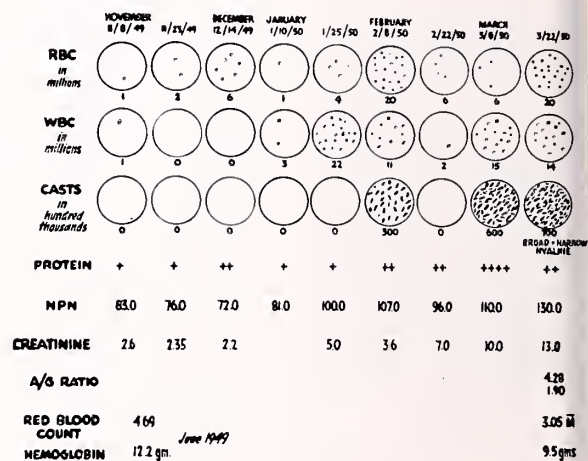


Fig 3 (Case 3) URINARY SEDIMENT AND PROTEINURIA IN 24 HRS.

### Comment

It may seem bizarre that on several occasions his urine showed so little, but it is important to realize that general diffuse damage of renal tissue may produce little of interest in the urinary sediment until specific nephrons begin to fall apart. This, we assume, is what has occurred when we have obtained urines showing casts and blood cells. It is worth noting that the casts are of different types. This may be interpreted as representing damage in different portions of the kidney—viz., broad casts are formed in the lower portions of the collecting tubules and the very narrow hyaline casts probably come from nephrons with narrowed lumens due to cellular edema.<sup>2</sup>

Obviously, accurate criteria for prognostic purposes are found in the blood chemistry. The gradual elevation of the NPN and creatinine is a death warrant. The profound anemia noted March 22 is the result of nitrogen retention. It is not commonly realized that nitrogen retention, particularly creatinine, causes a depression of bone marrow activity. It is worth remembering that unexplained anemias warrant a check of the blood creatinine, as the use of iron, liver and other hematinics is valueless in treating this type of blood deficiency.

<sup>2</sup> Ibid, p. 37.



### Case Presentations

**CASE 4.** Mrs. C.L., a 25-year-old woman, first saw one of us (A.V.M.) August 1949. In 1943 a urinalysis showed albumin and she was told she had nephritis. Four years later she was therapeutically aborted because of renal disease. Her past history was otherwise non-contributory.

**Physical Examination.** Her blood pressure was 106/64. There was a moderate amount of pyorrhea. There were no other significant physical findings. Because of the marked pyuria and hematuria and the absence of casts, the patient was cystoscoped and retrograde pyelograms were done to definitely rule out renal anatomical defects. All roentgenograms were normal. Intravenous urograms had to be cancelled because of severe nausea following the administration of dye. Urine cultures from both ureters were positive for hemolytic *Staphylococcus albus*. Sulfadiazine therapy was instituted with equivocal results.

The urea clearance test was normal. A PSP excretion test showed 40 per cent of the dye in the urine in 15 minutes. Random urinalyses showed concentration from 1.004 to 1.022. Proteinuria was persistent. Red blood cells and white blood cells with occasional pus clumps were seen in varying amounts.

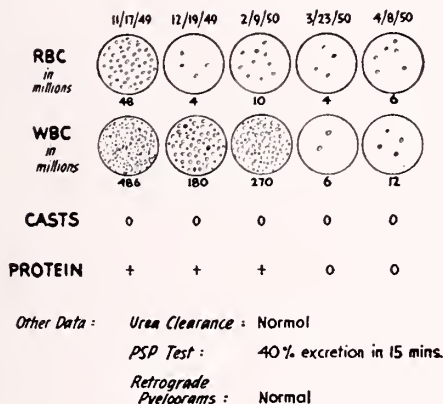
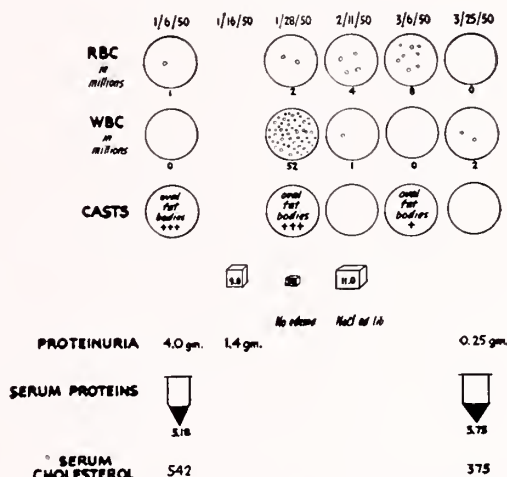


Fig. 4 (Case 4) ADDIS COUNTS (24 HOUR EXCRETION RATE)

Early in November this patient advised us she had not menstruated for over two months. Pregnancy was confirmed. The first Addis count on November 17 favored a diagnosis of pyelonephritis (Fig. 4). A repeat urine culture was positive for hemolytic *Staphylococcus aureus*. Penicillin and aureomycin therapy was started. This was followed with small doses of sulfacetamide. Her Addis count on February 8, 1950, was disturbing. The presence of red blood cells in profusion raised the possibility of a latent glomerulonephritis with a complicating pyelonephritis. However, the overwhelming number of white blood cells and the absence of casts on careful examination of qualitative and quantitative urine sediments seemed ample confirmation of the diagnosis of pyelonephritis. Because of peripheral edema and weight gain, the patient was put on a 1200 calorie, low sodium diet. Her protein intake was set at approximately 65 grams. Sulfacetamide was discontinued and sulfisoxazole was substituted.

We kept in touch with the patient via telephone. She missed her next appointment, but she was coerced into

visiting us March 23, at which time her edema had disappeared and the urinary sediment was much clearer than on her previous visit. The urinary sediment is not yet normal, but it is much less abnormal than it was before therapy was instituted. These findings are reassuring, and since she is still in good condition, we are justified in being optimistic. In addition, we may halt the infectious process which has attacked her kidneys by rationally approaching the diagnosis of the condition. If at any time after therapy was instituted we had found casts, protein and cells in the urine, we would have considered aborting her, as these findings usually presage a renal accident during pregnancy.



was no proteinuria. She complained of being tired, so her sodium intake was increased to 5 grams daily. Since she remained free of edema, her salt intake was soon thereafter not limited.

Her blood chemistry now is nearly normal and she is clinically well. It will be necessary to study her urines for a few more months to be assured of kidney healing. The laboratory tests have been of diagnostic aid and they have served as a therapeutic guide.

### Discussion

It is not the purpose of this paper to discuss the value of a low protein diet in renal disease. Let it suffice to say that we are satisfied this type of dietary management has a very real bearing on the eventual status of the diseased kidney. We do wish to stress that the laboratory work cited can be done in any physician's office with a small monetary investment. It is important that all procedures must be simple as well as inexpensive, since the patient may be coming in for a period of months to years. The laboratory methods described by Addis<sup>1</sup> meet these criteria.

Regularly checking a timed urine of patients who have renal disease may give valuable information. It is of particular interest in patients with subsiding acute glomerulonephritis, as a careful study usually reveals that the kidney has not healed despite the apparent well-being of the patient. The so-called "routine urinalysis" is worse

than useless since the presence of an "occasional red blood cell," "scattered white blood cells" and "few hyaline and granular casts" is usually passed off as normal by most physicians. Utilization of Addis' techniques at regular intervals in the instance of Case 1 might well have prophesied the onset of the degenerative phase and treatment could have been instituted earlier.

The examination of urinary sediment is simple. Obviously the physician looking through the microscope will not always correctly identify what he sees. However, by diligently studying frequent specimens from different forms of renal disease, he will gradually learn to recognize patterns, so that even the novice may obtain much satisfaction from correlating the clinical picture with the renal pathology as mirrored in the urine.

### Summary

The laboratory data and case histories of 5 patients with renal disease are presented.

Frequent, simple and inexpensive laboratory procedures may serve as diagnostic and therapeutic aids.

It is advantageous for the physician to examine laboratory specimens personally, so that his final evaluation of the patient may be a total one.

<sup>1</sup>1133 Punchbowl St.



# Venous Thrombosis and Pulmonary Embolism

ROGERS LEE HILL, M.D.  
HONOLULU

**M**ASSIVE pulmonary embolism is a dramatic and catastrophic event, that strikes fear in the hearts of all practicing physicians and causes sudden death to the unfortunate patient. You have all undoubtedly witnessed the unpleasant and unforgettable scene, of the sudden demise of a normal healthy individual on or about the seventh postoperative day, recovering satisfactorily from an uncomplicated operation, such as a herniorrhaphy. I shall carry such a picture with me to my grave, and must confess that the constant fear of such a tragedy was one of the great mental obstacles I had to overcome in the practice of surgery. Fortunately, in Hawaii this complication is infrequently encountered as compared to regions with a colder climate. Presumably this disparity is due to the abatement of circulatory stasis in the colder climate by arterial spasm.

Many of the pulmonic episodes frequently observed by us during postoperative recovery undoubtedly result from minor non fatal emboli, and have been erroneously attributed to pneumonia or atelectasis. We estimated recently, from a not too accurate survey, that our incidence of fatal massive pulmonary embolism was about one-fifth of that observed in some of the large northern mainland clinics. The period between 1926 and 1929, for some strange reason, represents the black years of high frequency of pulmonary embolism in various countries. It is also of great interest that the death rate from pulmonary embolism in Sweden was twice as high in the private rooms as in the wards. An unusually low incidence of pulmonary embolism was observed in Germany during the World War I (starvation years).

Only about 25 per cent of pulmonary emboli are fatal in the first attack. Death from this complication may be instantaneous, but usually takes place after a struggle of five minutes. In 50 per cent of the cases death occurs about ten minutes after the onset. This delay of ten minutes prompted the attempted removal of the embolus from the pulmonary artery in order to restore circulation. It was first successfully tried by Tren-

delenberg, in 1907, on animals and on a patient by Kirschner in 1924. Pulmonary embolectomy occupied the limelight for only a brief period, with indifferent success, and was discarded because of the realization that the saving of life was a rare occurrence, and a more fundamental and prophylactic approach was necessary for satisfactory solution.



DR. HILL

A forward and historic step was made in the discovery that the site of origin of the blood clot and the major source of most pulmonary emboli, was in the deep veins of the leg. Prior to this it was thought to be either in the pelvic veins or the right side of the heart, which contributed materially to a prevalent defeatist attitude for some time. Differentiation of the bland clot from the inflammatory clot, with the coinage of the terms phlebothrombosis and thrombophlebitis, was a major contribution because the former is a frequent precursor of pulmonary emboli and the latter only in isolated circumstances (liquefaction of the clot by liberated ferments as a result of suppuration, or the formation of a bland clot proximal to the inflammatory clot). While illness, parturition, trauma and surgical procedures are conducive to thrombus formation, the underlying basic principle in the establishment of thrombosis is stasis in the leg veins, dependent on bed rest and muscular inactivity. This premise has resulted in not only a great deal of attention devoted to early recognition of leg vein thrombosis (calf muscle tenderness, slight ankle swelling, superficial vein dilatation), but the institution of vigorous measures, such as active leg mobilization; deep breathing; early ambulation; atraumatic surgical technic; and elimination of abdominal distention, obesity and circulatory collapse, to prevent such an occurrence.

Elevation of temperature and pulse rate associated with the above signs of leg vein thrombosis reliably indicates that a small infarct has occurred.

Read before the staff meeting of The Queen's Hospital, February 16, 1950.

It should be emphasized that the strict categorical differentiation of phlebothrombosis from thrombophlebitis is not always desirable, because some of the cases of phlebothrombosis develop thrombophlebitis in time, which might lead to ill advised conservatism.

The next logical step in the treatment of thromboembolic disease was the introduction of femoral vein interruption in 1934. The selection of the superficial femoral vein as the site for therapeutic occlusion was not done in a haphazard fashion, but because it was the drainage source for many of the muscle veins most likely to become thrombosed during stasis, and also because it could be divided without disabling sequelae. This occlusive therapy was extended to the femoral of the opposite side, and cephalad, to include the iliac and even the inferior vena cava in an attempt to produce the point of obstruction at the logical site — proximal to the clot formation — in order to circumvent the danger of dislodging the clot during operative maneuver. The disabling post-operative sequelae (edema, ulceration, venous engorgement and induration) have been the chief deterrents to common femoral and iliac ligation and it is reasonable to assume that eventually they will be discarded for the superficial and vena cava procedures.

Superficial femoral thrombectomy with removal of the clot, when it is apparent that the clot has extended into the common femoral and even higher, has been successfully used, but carries with it the hazard of dislodging a portion of the clot during attempted removal. In patients who are too ill to undergo a vena cava ligation, and who have a definite extension of the coagulation process beyond the junction of the superficial femoral and deep femoral veins, it may be life-saving.

The recognition of vulnerability of certain patients to thrombosis (and in the absence of a sensitive laboratory test to indicate these potential thrombosers) has been of tremendous value in the development of prophylactic treatment of thrombosis and embolism. Patients who have trauma to the lower extremities, abdominal malignancy, or cardiac decompensation, or who are over 65, are particularly vulnerable to this dreaded

complication and are suitable candidates for bilateral prophylactic superficial femoral vein interruption. Fractures of the femur, and amputative procedures, are noteworthy offenders.

There is no doubt about the value and efficiency of anticoagulant therapy in treatment of thromboembolic disorders, providing reliable laboratory facilities are available, and certain conditions are regarded as relative or even absolute contraindications, namely: (1) significant hepatic and (2) renal insufficiency, (3) ulcerative lesions of the gastrointestinal tract, (4) purpura (5) blood dyscrasias, (6) certain operative procedures on the brain or spinal cord, and (7) hypertension. It is difficult to see how anticoagulants will prevent the dislodging of a clot already formed, but the proof of the pudding is in the eating thereof and the reported statistics are undeniably good. The judicious use of combined anticoagulant therapy and vein ligation has merit.

Ligation of the inferior vena cava is definitely indicated in septic thrombosis of the pelvic veins. A sufficient number of ligations have now been performed to demonstrate its feasibility and reasonable safety without too many disabling sequelae. The indications for its use will undoubtedly be broadened in the future. The chief disadvantage is the necessity for administering either a general or spinal anesthetic.

Despite the prosecution of a vigorous policy toward obliterating or reducing mortality in thromboembolic diseases, with apparent success, it is possible statistically to demonstrate that more deaths occur now than a decade ago. Paradoxical as this is, it has been explained by the increased span of life and greater magnitude of operative procedures to eradicate cancer, with an appreciable increase in the number of vulnerable patients. While an evaluation of the present prophylaxis and treatment of venous thrombosis and pulmonary embolism leaves much to be desired, one cannot help but speculate that in the near future sensitive laboratory tests and anticoagulant drugs with a wide margin of safety will relegate this distressing complication to the forgotten past along with other problems that at one time appeared to be equally insurmountable.



# Hawaii

## MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D.	Editor
LYLE G. PHILLIPS, M.D.	Editorial Director
MRS. EDITH C. BENNETT	Managing Editor
LAURENCE M. WILG, M.D.	Notes and News Editor
ROGERS LEE HILL, M.D.	Advisory Board
JAMES R. ENRIGHT, M.D.	Advisory Board
HASTINGS H. WALKER, M.D.	Advisory Board
PETE OKUMOTO, M.D.	Associate Editor, Hawaii
KEITH KUHLMAN, M.D.	Associate Editor, Kauai
E. T. SHIMOKAWA, M.D.	Associate Editor, Maui

### [ EDITORIALS ]

#### PAN-PACIFIC SURGICAL CONGRESS — 1951

**The Fifth Congress of the Pan-Pacific Surgical Association will meet in Honolulu November 10-21, 1951.**

**All countries bordering on the Pacific Ocean are cordially invited to send representatives to this meeting, where they will meet and become acquainted with prominent surgeons from many Pacific countries.**

**All surgical specialty sections will be represented on the scientific program. Breakfast round table discussions will be held daily and motion pictures on surgical subjects shown.**

#### CORTISONE FOR BURNS

The spectacularly rapid healing of superficial thermal burns under treatment with ACTH or cortisone, described last fall by Whitelaw and demonstrated in further unreported Army cases in Korea and Japan and at Tripler Army Hospital, unquestionably requires critical review of preparations for treatment of large numbers of burn casualties which an atomic explosion might produce. A therapeutic agent which may virtually eliminate the need for transfusions of blood or plasma; which may eliminate the necessity for dressings completely; which may permit extensively burned persons to be ambulatory within 2 or 3 days; which may make it feasible, in the event of need, to treat such persons in their own beds at home, cannot be ignored in our planning.

In the first place, the actual cost of treating extensive burns, as Whitelaw has pointed out, would be reduced to a small fraction of the cost of present methods. In the second place, the problem of hospitalizing thousands of burn cases, which is virtually insoluble if present methods

must be used, would be enormously simplified, since presumably a large proportion of burn victims could be allowed to remain at home and receive their cortisone or ACTH there from a visiting nurse.

But in the third place, there isn't enough cortisone available now to meet current peace-time demands for it, let alone demands for stockpiling against an atomic attack in even one city, much less several. After the attack occurred, we might hope to obtain a large emergency allotment by air express; but for the present at least, we cannot possibly have stocks on hand in advance of the need.

So for the present, we can do two things. We can prepare ourselves to treat burns by methods now available, and we can treat every serious burn case with cortisone or ACTH in order to familiarize ourselves with the values and limitations of this astonishingly effective new method. Let's be sure we don't let our present supply of cortisone get so low that a badly burned patient could not have the benefit of its use.

### NO "CLOSED SHOP" FOR DOCTORS!

No hospital should require a physician on its staff to belong to the American Medical Association or any state or county medical association or society. Membership in these organizations is desirable for any practicing physician; for certain purposes it may even be necessary; but it is not a proper condition for admission to practice in a hospital.

Such a regulation is tantamount to the "closed shop" or "union shop" rule, as was brought out clearly in England a few weeks ago when a hospital in Durham ruled that their staff physicians must join the British Medical Association in lieu of belonging to a trade union. The B.M.A. rose up in wrath and condemned the regulation roundly; they wanted no part, said they, of a rule compelling doctors to join their organization.

Honolulu's hospitals do not require A.M.A. or county medical society membership of applicants for admission to their staffs. St. Francis Hospital, the last to have such a rule, abolished it some four years ago. Our hands are clean.

It is believed that there are hospitals in the United States which still have such a requirement. If so, they should abandon it, and the American Medical Association should urge this course of action upon them as strongly as possible.

The fact that disability and malpractice insurance can be sold more cheaply to organizations than to individuals, is a basic and inescapable economic fact, and must presumably remain as a strong inducement to join a component organization of the A.M.A. The fact that most of the American Specialty Boards make A.M.A. membership a prerequisite for applicants (as of 1949, the Boards of Pathology and Pediatrics did not) might well be critically re-examined. By and large, a physician ought to join his county medical society and the A.M.A. because he wants to, not because he is compelled to do so.

### "FREE" CHOICE OF PHYSICIAN IN ENGLAND

"I am directed by the Minister of Health to say . . . he has decided that it is desirable to place some restriction on the right which persons have hitherto had to transfer immediately from one National Health Service doctor to another. . . ."

So, according to *Medical Economics*, runs a recent release from Whitehall, London.

Translated into simpler language, this means "Patients can no longer choose their own doctor unless the Government says it's all right."

### POST-PARTUM PLASMA

Successful treatment of chronic rheumatoid arthritis by infusions of plasma from post-partum patients was suggested by Granirer in *Science* over a year ago, and a further progress report was made at the New Jersey State Medical Society meeting in the summer of 1950. The remarkably prolonged effect of this method of treatment, as contrasted with the extremely transitory effect of single doses or short courses of cortisone or ACTH, was a particularly striking feature.

The report of a steady rise in serum globulin during the latter trimester of pregnancy and the early post-partum period, as described elsewhere in this issue by Hamilton and Higgins, invites the speculation that this change may bear some relationship to the observations made by Granirer. The beneficial effect of pregnancy on arthritis is familiar to all, but if this benefit can be passively transferred by transfusions of blood or plasma from pregnant or post-partum women, it may be made much more widely available. We trust there will be further reports of trials of this method, not alone in arthritis, but in other disorders which are helped by ACTH or cortisone.

### THE MEDICAL LIBRARY IS READY TO SERVE YOU

All day through the week, and five evenings a week, your County Medical Library stands ready to serve members and associate members of the County Medical Societies of Hawaii, the Nurses' Association of Hawaii, and staff members of the organizations which contribute annually to the Library. Use of materials in the Library, without loan privileges, is extended to all military medical personnel, University students, and research workers.

Bound volumes of periodicals are allowed to go out on loan for only three days at a time, and if they are returned overdue, each issue included in the volume will be subject to the usual fine of five cents per day. The minimum fine for any lost volume has been set by the Board of Governors of the Library at \$25.00; this is not an economical way to purchase books for yourself.

The three-day limit on bound volumes seems short, but it is really not unreasonable. You can get what you need out of a journal in that length of time if you're working at it. It's a little reminiscent of Toots Shor's remark about the midnight deadline on serving liquor in New York City. "If a bum can't get drunk by midnight," said Mr. Shor tersely, "he ain't tryin'."



## MEDICAL NEWS

Oral treatment of **pernicious anemia** with vitamin B-12 is not recommended. Responses to even massive doses are unpredictable (Meyer, L. M., et al., *Am. J. M. Sci.* 220:604 [Dec.] 1950). One authority is using 5 mg. folic acid daily by mouth, and 30 micrograms of B-12 intramuscularly once or twice a month.

**Bell's palsy**, usually treated with (misleading) reassurance, responds to **intravenous histamine**, according to G. L. Loomis, who reports success in 5 cases. Rationale: relief of spasm of the stylomastoid artery which supplies the seventh nerve. (*Arch. Otolaryng.* 52:948 [Dec.] 1948.)

**Vomiting in children** (due to motion sickness, "infant regurgitation," and "epidemic vomiting") can be prevented or relieved promptly by oral 5 cc. doses of a phosphoric acid-invert sugar solution ("**Emetrol**"—Kinney & Company, Columbus, Ind.). Direct inhibition of smooth muscle is the probable mechanism. Bradley, et al., report excellent results in 246 cases. (*J. Pediat.* 38:41 [Jan.] 1951.)

Beierwaltes records preliminary testing of two new **antithyroid** drugs 1—methyl-, and 1 ethyl—2 mercaptoimidazole (Lilly). Both drugs are as effective as propylthiouracil, in much smaller dosage (10 mg., q.i.d.). There may be a higher incidence of progressive exophthalmos, due to the faster action of these drugs. (*J. Lab. & Clin. Med.* 36:861 [Dec.] 1950.)

**Surital**, a new **intravenous anesthetic** (Parke Davis), is said to produce less respiratory depression, laryngospasm, and circulatory depression than pentothal, by Gain, et al. (*Canad. M.A.J.* 64:32 [Jan.] 1951.)

**Histoplasmosis** in 12 children was treated with **ethyl vanillate** and 5 survived, an unparalleled record. (Christie et al., *Pediatrics* 7:7 [Jan.] 1951.)

**Sodium citrate** is highly recommended in **lead poisoning** by Shiels, et al. (*M. J. Austral.* 2:886 [Dec. 16] 1950.) Five grams, t.i.d., causes increased urinary excretion of lead, with prompt relief of symptoms.

Bleeding from **esophageal varices** can be controlled simply by **raising the foot of the bed** ten inches. Lorant (*Gastroenterol.* 16:716 [Dec.] 1950) says that by reversing the effect of gravity on the blood in the esophageal veins, they will drain away from the cardia and bleeding will cease. He reports 5 out of 6 cases recovered, an impressive record even with more complicated forms of treatment.

Use of **cortisone** after operation for **Dupuytren's contracture** is reported to soften the residual fibroblastic tissue and prevent recurrence. (Baxter, H. et al., *Canad. M.A.J.* 63:540 [Dec.] 1950.)

Another method of removing nitrogenous wastes from a patient in **uremia** is described by Bernstein, et al. (*J. Lab. & Clin. Med.* 36:849 [Dec.] 1950.) They run 18 liters of a glucose saline solution through a double-lumen gastric tube and drain it through a rectal tube at the rate of 2.5 liters per hour. The patient becomes distended, but suction is applied to the proximal end of the gastric tube to prevent dilatation of the stomach. The method is unperfected; chief problem: how to prevent the intestines from absorbing huge amounts of the perfusing fluid.

**Premenstrual tension** (painful breasts, tender abdomen, edema and nervousness) is relieved by **vitamin A**, 200,000 units orally daily during the second half of the menstrual cycle. Mechanism is thought to be an increase in the liver's ability to inactivate circulating estrogens. (Argonz and Abinzano, *J. Clin. Endocrinol.* 10:1579 [Dec.] 1950.)

**Potassium paraaminobenzoate** was used to treat **dermatitis herpetiformis** in 16 patients by Zarafonitis, et al., with partial to complete remission in all. Relapse occurred ten days after stopping the drug, but control was maintained for as long as thirty months by continued administration. (*Arch. Derm. & Syph.* 63:115 [Jan.] 1951.)

**Penicillin procaine** is much more effective than antitoxin in the prophylactic treatment of **tetanus**, according to Taylor and Novak (*Ann. Surg.* 133:44 [Jan.] 1951), but only if it is **injected into the area** infected with tetanus spores. Penicillin given parenterally does not penetrate the pus pocket.

**Dibenamine**, a direct antagonist of epinephrine, has provided relief in **status asthmaticus** (!). This paradoxical effect is attributed to blockade of the pressor effect of epinephrine (thus reducing pulmonary arterial pressure and relieving edema) without diminishing the bronchodilator action of epinephrine. Klotz and Bernstein (*Ann. Allergy* 8:767 [Nov.-Dec.] 1950) used 5 to 7 mg. per kilo orally or intravenously in 20 patients.

**Viomycin** is active against **streptomycin-resistant tubercle bacilli**, but the bacteria became resistant to viomycin just as rapidly as they do to streptomycin. There is considerable nephrotoxicity in man. Developed simultaneously and independently by the Chas. Pfizer Company (*Streptomyces puniceus*) and by the Parke Davis Company (*Streptomyces floridiae*). Nine articles. *Am. Rev. Tuberc.* 63:1-62 [Jan.] 1951.

**Merdroxone**, a new mercurial **diuretic**, is reported to be just as effective and safe for subcutaneous use as thimerin. (McHardy et al., *South M. J.* 44:44 [Jan.] 1951.)

The **vulva** appears purple in health, deep purple in pregnancy, red and purple in abortion, and yellow brown during the menopause when viewed in a dark room with a **Wood's light**. This new and colorful diagnostic method is discussed and illustrated by Benson et al., *Surg., Gynec. & Obst.* 92:14 [Jan.] 1951.

**Sulphydryl compounds** (cysteine and glutathione) are reported to increase the survival rate after exposure to lethal doses of x-rays. Most important, these compounds were protective no matter when they were administered—both before and after the irradiation. This may be of considerable importance in the treatment of **atomic-bombing casualties**. (Chapman et al., *Radiol.* 55:865 [Dec.] 1950.)

**Cashew nutshell oil** given in three doses of 4 gms. five days apart is reported to be more effective than any previous drug in the treatment of human **ancylostomiasis**. (Eichbaum, F. W. et al., *Am. J. Dig. Dis.* 17:370 [Nov.] 1950.)

**Benadryl** and **scopolamine** are as effective as Dramamine in the control of **motion sickness**, while Thephorin and Neo-Antergan are quite ineffective, according to Chinn, H. I. et al., *Arch. Int. Med.* 86:810 [Dec.] 1950.

If recurrent **renal calculi** are of the **phosphate** type, they can be prevented by the combination of a **low phosphorus diet** and oral use of **aluminum gels**. (Shorr and Carter, *J.A.M.A.* 144:1549 [Dec. 30] 1950.)

**Diabetes** may be induced or made **insulin-resistant** by **ACTH** or **cortisone**. Geller et al. report a diabetic patient whose insulin requirement rose to 700 units per day after cortisone, and remained that high after its discontinuance. **Nitrogen mustard** caused prompt disappearance of the insulin resistance. (*Arch. Int. Med.* 87:124 [Jan.] 1951.)

Chest pain due to acute **coronary thrombosis** can be promptly relieved by spraying **ethyl chloride** on a few "trigger" spots on the anterior chest wall. Travell describes the technique in *Circulation* 3:120 (Jan.) 1951.

C. A. DOMZALSKI, JR., M.D.



# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*  
MISS KATHERINE NEWHALL, *Assistant Librarian*  
Phone 6-5370

8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.

Monday through Friday

Closed Saturdays at noon and Sundays

Closed all day and evening on National holidays  
and at noon on Territorial holidays

## RECENT ACQUISITIONS

### Biography

Fischer, Martin. *Christian R. Holmes, man and physician*. c1937. (gift of Dr. Fennel)

Fischer, Martin. *William B. Wherry, bacteriologist*. c1938. (gift of Dr. Fennel)

### Dentistry

Fischer, M. H. *Death and dentistry*. c1940. (gift of Dr. Fennel)

### Dermatology

Lever, W. F. *Histopathology of the skin*. c1949.

### Dictionaries

Veillon, Emmanuel, ed. *Medical dictionary*. (English-French-German.) c1950.

### Electrocardiography

Hecht, H. H. *Basic principles of clinical electrocardiography*. c1950. (gift of publisher)

### Leprosy

de Souza-Araujo, H. C. *Leprosy survey made in forty countries (1924-1927)*. 1929. (gift of author)

### Medical Economics

Campbell, H. J. *Physicians federal income tax guide*. c1950. (gift of Schering Corp.)

Goldman, Franz, ed. *Medical care for Americans*. c1951.

### Medicine, Clinical

Graubard, D. J. *Clinical uses of intravenous procaine*. c1950. (gift of publisher)

Menkin, Valy. *Newer concepts of inflammation*. c1950. (gift of publisher)

### Nervous System

Burr, C. W., ed. *Curschmann's textbook on nervous diseases*. 2v. c1915. (gift of Mrs. B. Mobbs)

Orley, Alexander. *Neuroradiology*. c1949. (gift of publisher)

Walker, A. E. *Posttraumatic epilepsy*. c1949. (gift of publisher)

Weiss, Paul, ed. *Genetic neurology*. c1950. (gift of publisher)

### Nursing

Freeman, R. B. *Public health nursing practice*. c1950. (gift of publisher)

Goostray, Stella. *A textbook of chemistry (with laboratory manual)*. 6th ed. c1950. (gift of publisher)

### Ophthalmology

Ogle, K. N. *Researches in binocular vision*. c1950. (gift of publisher)

### Orthopedics

American Academy of Orthopedic Surgeons. *Instructional course lectures*. v.7. c1950.

Steindler, Arthur. *Postgraduate lectures on orthopedic diagnosis and indications*. v.1. c1950. (gift of publisher)

### Respiratory System

Jackson, Chevalier. *Bronchoesophagology*. c1950. (gift of publisher)

### Roentgenology

Shanks, S. C., ed. *A textbook of x-ray diagnosis*. v.3. 2nd ed. 1950. (gift of publisher)

### Surgery

Berman, J. K. *Principles and practice of surgery*. c1950. (gift of publisher)

### Therapeutics

American Therapeutic Society. *Transactions of the 48th and 49th annual meetings*. v.48-49. c1950. (gift of American Therapeutic Society)

Jones, J. M., ed. *Physicians' desk reference*. 1951. 5th ed. c1950. (gift of publisher)

\* \* \*

The Library wishes to acknowledge with deep appreciation the Cancer Society's contribution of five hundred dollars. The cancer collection has been widely used during the past year, and this new contribution will insure the continued growth of this important field. Moreover, we have been able to complete binding of our journal files on cancer, thus assuring their permanency. With these extra funds, we were also able to subscribe to the *Japanese Journal of Cancer*, GANN. Several Japanese doctors are doing interesting experimental work in cancer, and doctors should come to the Library and familiarize themselves with this new journal.

\* \* \*

The Library wishes to acknowledge with thanks the contributions which have been received from the specialty societies, which enable us to continue our subscriptions to several sections of the *Excerpta Medica*. At the present time, the following groups have given us their checks:

Hawaii Dermatological Society .....	\$25.00
Hawaii Chapter, American College of Physicians .....	37.50
Honolulu Society of Neurology and Psychiatry .....	22.50
Honolulu Surgical Society .....	25.00

Dr. Louis L. Buzaid has also generously continued his contribution of \$15.00 for the Radiology section of the *Excerpta*.

## BOOK REVIEWS

---

### **What You Should Know about Cancer of the Breast from the Patient's Viewpoint.**

By a Radical Mastectomy Patient. 32 pp. Honolulu, 1951.

The author is probably sincere about her anxiety to help prospective mastectomy patients. However, the two photographs of post-operative results tend to defeat this purpose because of their gruesomeness, and are not necessary. Patients undergoing mastectomy should realize that the majority do not have all the troubles stated by the author. There are about ten different types of incision described for radical mastectomy; and the statement that transverse incision will cause the patient to have greater difficulty in regaining arm movement because of interference with nerve centers is incorrect. Not all patients have a swollen arm, as described so vividly and pathetically by the author. Furthermore, many patients already have the swollen arm before the operation, due to minute pre-operative axillary metastases. Otherwise, in general, the statements made in the pamphlet are fairly reliable.

LESTER YEE, M.D.

### **Genetic Neurology.**

By Paul Weiss, Editor. 239 pp. Price \$5.00. The University of Chicago Press, Chicago, Ill., 1950.

This book is a symposium of essays by members of the International Conference on the Development, Growth and Regeneration of the Nervous System. The Conference, whose members come from many parts of the world, met in Chicago in March, 1949, under the chairmanship of Dr. Paul Weiss.

As the name indicates, the subject matter is of a rather specialized nature and therefore will have a limited appeal. However, to those interested in the problems of the nervous system, the impressions and thoughts of the investigators after discussing their problems with each other will prove very stimulating.

JOHN J. LOWREY, M.D.

### **Clinical Uses of Intravenous Procaine.**

By David J. Graubard, M.D., and Milton C. Peterson, M.D. 104 pp. Price \$2.25. Charles C. Thomas, Springfield, Ill., 1950.

This monograph in anesthesiology is no. 73 of a series of medical monographs published by Thomas. As in the other members of the series, the type is large and clear, the paper glossy, the organization clear and the contents concise and practical. The title of Chapter 4 is given in the Table of Contents as "Pruritis" instead of "Pruritus," but in general typographical errors are few and far between. The chemistry and pharmacology of procaine, and its use in a wide variety of clinical situations, are discussed in detail, and the volume is highly recommended as a handbook (in the American, not the European sense) on the use of procaine by vein.

HARRY L. ARNOLD, JR., M.D.

### **Postgraduate Lectures on Orthopedic Diagnosis and Indications, Vol. 1.**

By Arthur Steindler, M.D., F.A.C.S. 302 pp. with 400 illus. Price \$7.50. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

This newest contribution from the prolific pen of Dr. Steindler is a much more readable and generally useful publication than many of his other ultra-technical monographs.

It is profusely illustrated with many well-selected photographs interspersed with diagrams clarifying the text, which at times becomes somewhat confusing. The text is well documented and the book is valuable for its extensive bibliography alone. He has drawn extensively from his previous publications.

The chapters in this first section are well titled; the sub-titling is most helpful in using the book as a reference work and admirably supplements the index. A list of authors is also valuable and one notes the many foreign contributors, which shows what a wide expanse of orthopedic literature is covered.

Little discussion is devoted to treatment and the author predicts that he is bound to be criticized for it but he calls attention that this book is for the beginner rather than for the mature surgeon and refers his readers to other works including those from his own pen for details of technic. He does, however, go into details in a few cases of congenital conditions such as talipes, to which a full chapter is devoted.

No inkling as regards the plan to be followed in the later volumes or when they are to appear is mentioned. Dr. Steindler has retired from active teaching at the University of Iowa where he has been for so many years and is devoting a large portion of his time to this work which, with such a wealth of material behind it, is of such great value. With later volumes this entire work will be a cyclopedia of orthopedics and should be in the working library of every physician interested in orthopedic conditions.

J. WARREN WHITE, M.D.

### **The Preparation of Photographic Prints for Medical Publication.**

By Stanley J. McComb, F.B.P.A. 65 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

This book is one that every scientific writer should read, particularly one who is unfamiliar with photographic technic. The text and pictures make clear what a good medical photograph is so that the physician can go about taking his own pictures intelligently or can give explicit instructions to the photographer doing the work for him.

G. M. HALPERN, M.D.



### Bronchoesophagology.

By Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S. 366 pp. with 260 figures. Price \$12.50. W. B. Saunders Company, Philadelphia and London, 1950.

This excellent book is an outgrowth of the authors' previous textbook, "Bronchoscopy, Esophagoscopy, & Gastroscopy." The authors are championing the use of the term bronchoesophagology in lieu of the terms bronchoscopy and esophagoscopy. Bronchoesophagology is a branch of medical science which deals with the tracheobronchial tree and esophagus and their diseases, including the etiology, pathology, symptomatology, diagnosis, prophylaxis and treatment. Bronchoscopy and esophagoscopy are merely the mechanical or "viewing" part of this branch of medicine. With this in mind, the authors have proceeded to write a most comprehensive review of the subject.

The section on foreign bodies in the air and food passages is the finest I have read and is so illuminating that I feel that it should be read not only by the otolaryngologist and bronchoesophagologists, but also by the general practitioners and pediatricians who frequently are the first ones to be consulted.

The chapter on trauma of the laryngotracheal tree is disappointingly short. In view of the dangers of a new war, it was hoped that more would be written about this subject. However, the chapters on obstructive laryngeal disease and on obstructive conditions of the bronchial tree are excellent.

The section on the esophagus and its diseases is very comprehensive and covers the subject thoroughly. There is an especially good discussion on the hypopharyngeal diverticulum (esophageal diverticulum) and the authors' one stage operation for this condition.

The whole book is written in the typical Jackson style—concise, thorough, and easy to read and digest. It is well illustrated by the elder Jackson's own famous drawings and there are a few colored plates. This is the best textbook on this subject and is highly recommended for anyone interested in this branch of medicine and surgery.

L. Q. PANG, M.D.

### A Text-Book of X-Ray Diagnosis.

By British Authors in Four Volumes. Edited by: S. Cochrane Shanks, M.D., F.R.C.P., F.F.R.; and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E. Volume III (Second Edition). 830 pp. with 694 ill. Price \$18.00. W. B. Saunders Company, Philadelphia and London, 1950.

A comprehensive survey based on established diagnostic radiology. The collaborators are clinicians and radiologists. The volume includes diagnosis in the alimentary tract, biliary tract, abdomen, obstetrics and gynecology and the urinary tract. Each section is preceded by a brief review of pertinent anatomy and physiology. Correlated with roentgen diagnosis are the clinical aspects, microscopic and gross pathology. The text designed for convenient reference maintains the readers' interest continuously. Remarkable is the section on radiology of obstetrics which will interest every obstetrician since it relates and evaluates the numerous diagnostic methods and modification utilized in pelvimetry. The cost of four volumes may discourage the prospective purchaser because comparable less expensive publications by American authors are available.

L. L. BUZOID, M.D.

### Your Prostate Gland.

By Reed M. Nesbit, M.D. 50 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

This short volume is a collection of letters from an M.D. son to his father, a layman. It is written in simple understandable terms and illustrated by simple sketches. The anatomic, physiologic, and pathologic changes that take place are clearly explained. The types of surgical procedures are briefly described. Furthermore, erroneous ideas that have been spread among the public by charlatans are corrected. For the layman suffering from prostatism, this is an excellent explanation of the cause and treatment of his malady.

R. O. BROWN, M.D.

### Thromboembolic Conditions and Their Treatment with Anticoagulants.

By Charles D. Marple, M.D., and Irving S. Wright, M.D. 416 pp. with 27 ill. Price \$8.50. Charles C. Thomas, Publisher, Springfield, Ill.

During the past decade thromboembolic complications have become increasingly important in medicine and surgery. Probably the most stimulating factor for early recognition of these complications was the therapeutic approach offered by the discovery of anticoagulants. Our present knowledge concerning anticoagulants is elementary and much is to be learned about their use.

The monograph is the first comprehensive book I have seen covering the pertinent information necessary for the treatment and prevention of thromboembolic phenomena. The bulk of the information is based on extensive clinical experience, well organized and clearly presented. It gives the physician confronted with these problems a clear cut picture of our present knowledge and offers definite therapeutic approach in the management of such complications. The book presents 684 well selected references.

HENRY C. GOTSHALK, M.D.

### A Textbook of Chemistry.

By Stella Goostray, R.N., and J. Rae Schwenck, A.B., Ch.E. Sixth Edition. 401 pp. Price \$3.50. The Macmillan Company, New York, 1950.

Judging from the selection of subject matter in this text, it evidently was written for student nurses. Yet, fifty-five per cent of the volume is devoted to inorganic chemistry. A nursing course ought not require that much review of pre-nursing chemistry.

The material is well arranged and the subject matter can be easily located. The inorganic chapters are very much detailed and clear, but that is not true of the organic chapters which are too general and fail to include much material relating to modern nursing and clinical medicine.

Each chapter begins with a "Chapter Survey" which is helpful in orienting the student to new subject matter, in making her more aware of its relation to nursing, and in stimulating her interest. Each chapter ends with a concise summary.

Among those topics which may prove most helpful are Inorganic Salts and Chemical Control of Body Processes. A laboratory manual accompanies the book. Only about one-sixth of it is devoted to organic chemistry.

Though the book will hardly suffice as a text in a progressive nursing school, each nursing school library should have a few copies for reference.

BERTHA SCHIFFMAN, R.N.

### Principles and Practice of Surgery.

By Jacob K. Berman, A.B., M.D., F.A.C.S. 1,378 pp. with 429 illustrations. Price \$15.00. The C. V. Mosby Company, St. Louis, Mo., 1950.

Dr. Berman's text deals with the application of the basic sciences to the principles and practice of surgery rather than with detail description of surgical diseases and surgical technics. He has correlated the basic sciences of anatomy, embryology, pathology and particularly physiology with the fundamental concepts of surgery. This book gives one an over-all understanding of all the elements of surgery, and, as might be expected in this type of a work, the various specialties of surgery have been touched upon but lightly. This sacrifice, however, seems more than justified by the readable presentation of surgical principles. Subject material covers the recent advances in physiology as well as surgery, the earlier chapters dealing with local response in general body reaction to various surgical diseases. The latter chapters are devoted to regional and systemic surgery.

JAMES W. CHERRY, M.D.

### Urgent Diagnosis without Laboratory Aid.

By Prof. Dr. Hanns L. Baur. 85 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

In spite of all admonitions in medical school and elsewhere, it is certainly true that the average American physician depends more on the laboratory for his diagnosis than on what the careful clinical appraisal of his five senses will tell him. This is probably not as true in other countries, particularly those in Europe where facilities of the laboratory are not as readily available and the physician has to rely more on the art of medicine than on its scientific approach.

Certainly the little handbook "Urgent Diagnosis without Laboratory Aid" is very refreshing reading. It is interestingly written. One can review the whole text in an hour or two. The theme of this little book is to emphasize the point that even with ample laboratory facilities, one may encounter emergencies in which an accurate diagnosis, or as accurate a diagnosis as possible, may mean a life-saving procedure for the patient before laboratory reports can be obtained. To this extent, it succeeds very well.

All physicians can profit by reading this text. I am sure all will find several points at least which we have forgotten since our medical school days in respect to the art of diagnosis in medicine.

L. CLAGETT BECK, M.D.

### Neuroradiology.

By Alexander Orley, M.D., F.F.R., D.M.R.&F. First Edition. 572 illus., 436 pp. Price \$11.50. Charles C. Thomas, Publisher, Springfield, Ill., 1949.

In this monumental work an attempt has been made to bring together under one cover all the information concerning the radiographic diagnosis of pathologic conditions involving the nervous system, including the cranium and its contents, the spine and changes in other parts of the body resulting from diseases of the nervous system. Although the field has not been completely covered in the book, it is adequate and fills a great need for the student of the nervous system.

In considerable detail technics are given for positioning of the head to obtain x-rays of the various pathological conditions. Deformities of skull, injuries, intracranial neoplasms are described. Diagnostic procedures, air studies and cerebral angiography occupy a large chapter. Diagrams and short case histories aid in interpreting the x-ray figures, many of which are poor, however. This is due to the fact that all x-ray figures are *reversed* positives, rather than negatives.

The section on angiography is well presented but is not complete. The percutaneous technics are not adequately described, nor are various technics for obtaining x-rays rapidly. There are no x-ray illustrations of phlebograms.

The section on the spine and spinal cord, including myelograms, occupies 72 pages. It is clearly presented but does not include examples of some anomalies of the spine, diplomyelia and deformities of the Klippel-Feil type. Carcinoma metastasis and tuberculosis of the spine are also omitted.

The bibliography of nearly 850 articles is an excellent reference source.

RALPH B. CLOWARD, M.D.

### The Clinical Use of Testosterone.

By Henry H. Turner, M.D., F.A.C.P. 69 pp. Price \$2.25. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

A great number of publications is reviewed in compiling the data in this short book which deals with the effects of testosterone upon the human body, both male and female. Actions and results that are controversial are presented. Conjectural modes of action are discussed even when the variance is great. There is some proven, practical information in this didactic monograph.

R. O. BROWN, M.D.

### Posttraumatic Epilepsy.

By A. Earl Walker, M.D. 28 illus., 80 ref., 6 tables. 90 pp. Price \$2.75. Charles C. Thomas, Publisher, Springfield, Ill., 1949.

This little volume of only 74 pages brings together in a compact form the vast amount of information on posttraumatic convulsions which has accumulated in the past 15 years, especially the experiences with war wounds of World War II. Dr. Walker, now Professor of Neurosurgery at Johns Hopkins University, has presented in a clear manner the physiology of seizures following injury; the neuropathology of the lesions, both brain and scar; and an excellent chapter on the neural activity gives a detailed account of the changes in electroencephalogram following cerebral trauma. Interesting comments on the chemical alterations in the brain during epileptic seizures give a new field for etiological investigation.

The medical and surgical treatment of epilepsy due to trauma are briefly but adequately discussed, as well as the results of such treatment. The book is short, easy to read and very informative.

RALPH B. CLOWARD, M.D.

### Also Received

#### Surgical Clinics of North America.

Philadelphia Number. Surgical Diagnosis and Premalignant Conditions. Pp. 1545-1863. Price \$18.00 per clinic year, cloth binding; \$15.00 per clinic year, paper binding. W. B. Saunders Company, Philadelphia and London, 1950.



# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 303rd regular meeting of the Hawaii County Medical Society was called to order by the president, **Dr. Leo Bernstein**, at 8:15 p.m., December 20, 1950, at the Lanai. **Dr. Robert B. Faus** of Honolulu was our guest speaker of the evening.

**Dr. Orenstein** reported on the Territorial Council Meeting held on December 15, 1950, in Honolulu.

**Dr. M. L. Chang** presented the Treasurer's report:

Cash on hand	
Savings .....	\$ 692.56
Checking Account .....	490.10
Total .....	\$1,182.66
Receipts (Dues) .....	2,900.00
Total .....	\$4,082.66
Disbursements	
Territorial Dues .....	\$1,107.00
AMA Dues .....	937.50
Library .....	342.49
Entertainment .....	393.45
Operational Expenses .....	84.26
Decoration of HMM Staff Room.....	147.20
Flowers .....	10.00
Total .....	3,021.90
Balance on Hand .....	\$1,060.76

There being no objections, the Treasurer's report was received as read. **Dr. Orenstein** suggested that the Territorial and AMA dues should be placed in a separate fund where they cannot be touched for other purposes.

**Dr. Robert B. Faus**, who needs no introduction to the members of the society, was then given the floor for the rest of the evening. He presented an over-all picture on (1) Civil Defense, (2) Selective Service of Medical Officers, and (3) HMSA.

The 304th regular meeting of the Hawaii County Medical Society was called to order by the president, **Dr. Leo Bernstein**, at 8:15 p.m., January 17, 1951, at the Hilo Yacht Club.

Letter dated January 2, 1951, from **Dr. S. Kasamoto**, Chairman of the Hawaii County Advisory Public Health Council, to the secretary of the Hawaii County Medical Society was read. This letter requested the approval of this society for fluoridation of the Hilo water supply for the purpose of reducing dental caries. **Dr. Leslie** moved that this society go on record as approving the fluoridation of the Hilo water supply employing the procedures recommended by the American Water Works Association. **Dr. Loo** seconded the motion and it carried unanimously.

A copy of the letter dated November 27, 1950, to **Dr. C. L. Wilbar, Jr.**, President of the Territorial Board of Health, from **Dr. John Sanders** was read. This letter opposed the Board of Health's Hansen's disease program discussed in "Facts and Fallacies about Hansen's Disease" and the "Standard Operating Procedures" dated September 25, 1950. No action was taken.

**Dr. Orenstein** was congratulated by the entire society on his silver wedding anniversary.

**Dr. Rogers Lee Hill**, President of the Hawaii Territorial Medical Association, presented his presidential message to the local society. Some of the highlights of his message were: his belief that Big Island hospitals should get subsidies for indigent care, his opposition to closed hospitals, the importance of the general practitioner, the importance of public relations, the importance of paying the \$25.00 AMA dues which made possible the one-half million dollar contribution to medical schools and the financing of the trip to Cleveland, Ohio, of the three Public Service Committeemen from Hawaii. He announced that the annual Territorial Medical meeting in Honolulu will be held on May 3-6, 1951. The postgraduate speakers will be **Dr. Nicholas J. Eastman** of Johns Hopkins and **Dr. Herbert F. Traut** of University of California Medical School. He invited everyone to attend and also to present papers.

After a short recess, **Dr. Richard C. Durant**, Chairman of the Public Service Committee, reported on the Third Annual Conference of the National Education Campaign of the AMA held in Cleveland, Ohio, December 7, 1950. He stated that the two Japanese doctors, **Dr. Kawasaki** and **Dr. Nishigaya**, who went along with him, made a tremendous hit at the conference. Dr. Durant discussed briefly "Public Opinion and Medical Practice on Oahu," a compilation of a public opinion poll on the Island of Oahu.

PETE T. OKUMOTO, M.D.  
Secretary

## HONOLULU COUNTY MEDICAL SOCIETY

The January meeting of the Society was held on Friday, January 5, at 7:30 p.m. at the Mabel Smyth Building. Present were **Dr. Samuel Yee**, presiding, and 137 members and guests.

The scientific program of the evening was presented by the members of the American College of Physicians with **Dr. Nils P. Larsen** conducting. **Dr. A. S. Hartwell** reported on "Highlights of Five-Day Program, A.C.P. at Mayo Clinic"; **Dr. M. E. Berk**, "Diabetic Survey of Hawaii"; **Dr. N. P. Larsen**, "Summary of Diagnoses of 10,000 Consecutive Medical Cases"; **Dr. H. L. Arnold, Jr.**, "Dermatological Diagnoses in Hawaii"; **Mr. M. A. Taff**, "Importance of Health Statistics"; and **Dr. N. P. Larsen**, "Weather in Relation to Allergy and Respiratory Disease."

A message from **Dr. Hill**, President of the Territorial Medical Association, was read by **Dr. Yee**, which stressed the importance of paying the \$25.00 AMA dues "to aid in creating a balance between public and private support for medical education." The AMA recently contributed 1/2 million dollars to 44 privately endowed medical schools which are in precarious financial condition, a donation made possible by the \$25.00 dues. There are 82 physicians in the Honolulu County Medical Society who have not yet paid their AMA dues.\*

Reports were made by **Dr. Hartwell**, Delegate to the AMA Interim Session, held in Cleveland early in De-

\* Reduced to 50 as of March 1.—Ed.



cember, 1950, and **Dr. Richard Durant**, Chairman of the Public Service Committee, who reported on the Third Annual Conference of the National Education Campaign of the AMA and the special public relations meetings on the county level.

Mimeographed copies of assignment of physicians to aid stations and hospitals were made available to the doctors who were present. **Dr. Faus** explained that the hospitals had made the initial plans and doctors were assigned accordingly. The result was that there were not enough doctors to take care of aid stations and therefore another plan was drawn up whereby physicians would be assigned to aid stations nearest their homes. He made it clear that the assignments were temporary and subject to change. We have passed the planning phase and are now moving into the training phase. It will be the responsibility of these doctors assigned to aid stations to train their personnel and to prepare them for service. In this connection **Dr. Faus** emphasized the importance of every physician taking additional training in radiologic defense, illness caused by radiation, standardization of treatment of burns, etc. A course on Medical Aspects of Atomic Explosions will be given on January 22, 24 and 26 from 7 to 9 p.m. and all physicians were urged to attend. **Dr. Faus** also stated that if anyone is dissatisfied with his assignment as listed he should take that up with the Preparedness Committee chairman. It was moved, seconded and unanimously carried that the Society adopt the plan in principle as presented by the Emergency Medical Service Committee.

**Dr. Arnold, Sr.**, stated that at a meeting of the Emergency Medical Service Committee action was taken to ask the Honolulu County Medical Society to recommend the establishing of a stand-by blood bank to function in the event that the present one is unable to operate. It was stressed that this stand-by blood bank is not a subsidiary blood bank requiring a lot of money for its establishment. It was moved, seconded and unanimously carried that the Society go on record in favor of the establishing of a stand-by blood bank to function in the event that the present one is unable to operate.

Meeting adjourned at 9:45 p.m. to refreshments in the lanai.

The February meeting of the Honolulu County Medical Society was held on Friday, February 2, at 7:30 p.m. at the Mabel Smyth Auditorium. Present were **Dr. Samuel Yee**, presiding, and 105 members and guests. **Mr. Jay C. Ketchum**, Executive Vice-President of the Michigan Medical Service, gave a short impromptu speech on "Voluntary Prepaid Medical Care" followed by a period of questions.

The scientific program of the evening was presented by the members of the staff of Leahi Hospital. **Dr. Walker** conducted the program as follows: **Dr. Robert Marks**, "Tuberculosis Control"; **Dr. Maurice Brodsky**, "Tracheal Lavage and Laboratory Diagnosis"; **Dr. R. N. Perlstein**, "Streptomycin and P.A.S."; and **Dr. Paul Gebauer**, "Tuberculous Bronchial Stenosis" illustrated by a movie made at Leahi Hospital and slides.

**Dr. Durant**, chairman of the Public Service Committee, reported that the results of the public opinion poll conducted by the Territorial Surveys for the Medical Society had been tabulated and completed in booklet form and were now ready for distribution to those mem-

bers who contributed \$10 or more to this survey fund. **Dr. Durant** read excerpts from the questions and answers that were received during the survey and recommended that we all peruse the booklet carefully in as much as he felt that we could improve our public relations if we knew better what the public actually thought of us. **Mr. Dan Clark** of the Territorial Surveys was present and offered to clarify anything regarding this survey.

A plan for establishing an emergency call service for physicians by the Honolulu County Medical Society was discussed by **Dr. Durant**. Copies of the plan had previously been sent to individual physicians and the returns were as follows:

Good idea, will serve.....	73
Good idea, will not serve.....	44
Good idea, will serve only specialty cases.....	6
	123
Bad idea, will not serve.....	9
Bad idea, will serve.....	1
Will not serve.....	3
	13

Discussion ensued in which **Dr. Durant** asked for approval of the plan subject to the acceptance of handling it by the Territorial Nurses Association. At the present moment they seem reluctant and would like more time to discuss it among themselves. Motion was made and carried that the Society proceed with the plan as outlined by **Dr. Durant**, subject to a reasonable financial arrangement with the Physicians' Exchange and reasonable expense to the Society.

At **Dr. Samuel Yee's** suggestion, a motion was made and seconded that **Dr. Durant** and his committee members be commended for their diligent and untiring efforts for better public relations. Motion was carried unanimously.

Budget approval for 1951-1952 then came up for discussion. The budget as presented by the Budget Committee had been previously approved by the Board of Governors. **Dr. Yee** brought out the fact that the Society has a reserve fund in U.S. Government Bonds of \$16,000, of which \$6,000 is redeemable at notice while \$10,000 is not redeemable for another 10 years. **Dr. Yee** also spent considerable time with the breakdown of the \$85 annual dues, which in round figures is as follows:

H.T.M.A.....	\$27.00 or 32%
Library.....	22.58 or 26%
County Society.....	35.42 or 42%

The Library asked for an increase of \$1750 of which one-half or \$875 was allowed, making a total of \$7,875. Discussion ensued regarding \$2,500 contribution to the Hawaii Visitors Bureau and \$501 to the Oahu Health Council. **Dr. Holmes** made an eloquent plea for continuing contribution to the Hawaii Visitors Bureau after which it was moved, seconded and carried that the general membership accept the budget committee's recommendations of cutting the above amounts down to \$1,000 to Hawaii Visitors Bureau and \$101 to the Oahu Health Council.

Discussion from the floor regarding \$3,000 for post-graduate speakers then followed. **Dr. Hartwell** commented that perhaps the American College Physicians may finance a two-week course on any subject the Society wishes, which would eliminate this expense next year. **Dr. Yee** stated that the matter had been discussed

and that a committee had been appointed to coordinate various offers and that it was our plan in the future to see what would be available without first offering \$3,000. **Dr. West** then moved that the budget for 1951-1952 as recommended by the Board of Governors be approved. Motion was seconded by **Dr. Lee** and carried.

**Dr. Kepner** announced that **Dr. Theodore Stone**, Professor of Nervous and Mental Diseases at Northwestern University will be in Honolulu on or about February 12. He will speak before the February 21 meeting of the Society of Neurology and Psychiatry on "Localization in the Cerebral and Cerebellar Hemispheres." An invitation was extended to all interested physicians. **Dr. Stone** is also scheduled to speak at the March 2 meeting of the Honolulu County Medical Society.

Meeting adjourned at 10:40 p.m. to refreshments in the lanai.

WM. M. WALSH, M.D.  
*Secretary*

### KAUAI COUNTY MEDICAL SOCIETY

The monthly meeting of the Kauai County Medical Society was called to order by **Dr. Goodhue** at 7:30 p.m., December 13, 1950, at Wilcox Memorial Hospital Library.

**Dr. Kemp** informed the members that the Board of Health would mail copies of the correct procedure in filling out birth and death certificates. **Dr. Kemp** also announced that the Board of Health would no longer be financially liable for any x-rays taken for food handlers, barbers, and dairy workers. These persons are to be referred to Mahelona Hospital for their chest x-rays.

The meeting had been preceded by two movie films on Surgical Technic in Thyroidectomy and Abdominal Surgery.

K. F. KUHLMAN, M.D.  
*Secretary*

### MAUI COUNTY MEDICAL SOCIETY

A regular dinner meeting of the Maui County Medical Society was held at the Maui Grand Hotel on January 16, 1951, at 6:15 p.m. with **Dr. Cole** presiding. **Drs. R. L. Hill** and **Isaac Kawasaki** were guests.

**Dr. Hill**, President of the Territorial Medical Association, addressed the Society, discussing the problems of the Association and its progress up to the present time.

He stressed the importance and value of paying the \$25 AMA dues and urged members who have not paid their dues to do so. In closing he mentioned the booklet on "Burn Therapy" prepared by **Dr. Cherry** and himself. A copy was mailed to every society member for his perusal.

**Dr. Kawasaki**, member of the Public Service Committee, reported on the highlights of the recent Cleveland meeting of the AMA concerning public relations and civil defense. In this connection he described comprehensively the present defense set-up of the Kuakini Hospital. He also reported on the results of the Public Opinion Survey conducted in Honolulu.

**Dr. Sanders**, Chairman of the County Advisory Committee, announced that his committee is meeting with the local legislators tomorrow night to discuss the proposed bill concerning the program of medical care of indigent and medically indigent under the control of the Territorial Board of Health. He suggested that we do away with the present position of government physicians and treat indigents on a fee for service basis with free choice of physicians at a county level. **Dr. Toney** pointed out to the members the problems involved in a county set-up particularly regarding its clerical work. **Dr. Hill** added his comments on the question expressing his feeling that the Board of Health control of the medical care of indigents at the present time would be practical and desirable and a step forward in the right direction. Further discussion followed.

**Dr. McArthur** moved that the Society approve the action of the Advisory Committee to accept the proposed bill. Motion was duly seconded and carried by one dissenting vote.

On the matter of the \$25 AMA dues, **Dr. McArthur** reiterated the stand of **Dr. Hill** and asked the members to support it 100 per cent. On our Civil Defense program, he stressed the importance of being more practical and suggested that the members direct their efforts toward a campaign for mass immunization, blood typing and first aid training.

A breakfast meeting of the Maui County Medical Society was held at the Puunene Club house at 8:20 a.m. on January 21, 1951, with **Dr. Cole** presiding. **Colonel Leedham**, Chief of Medicine of Tripler Army Hospital, was present by invitation, and gave an interesting and instructive lecture on rheumatic fever.

SEIYA OHATA, M.D.  
*Secretary, pro tem.*



# NOTES AND NEWS

## PERSONALS

**Dr. B. Allen Richardson**, who was born and raised in Kealahou, Hawaii, has recently opened his offices at 1286 Queen Emma Street, Honolulu, where he is specializing in orthopedic surgery. Dr. Richardson received his preliminary education on the Big Island and was graduated from the University of Hawaii in 1940, following which he attended the Yale University Medical School and was graduated in 1943. He entered the Medical Corps of the United States Army and served from 1944 to 1947, when he was honorably discharged as a Major. Dr. Richardson began his specialization in orthopedics at the University of Pennsylvania Graduate School of Medicine in 1947-1948, following which he served as a resident in orthopedics at the Hospital of the University of Pennsylvania, Philadelphia from July 1, 1948, to January 1, 1951. Dr. Richardson is married and has two children. His numerous friends welcome Dr. Richardson back to Honolulu and wish him much success in his chosen field of orthopedics.

The St. Francis Hospital, Honolulu, has recently added to their interne staff four new graduates of Japan Medical Schools. These graduates recently arrived in Hawaii by special arrangements with the authorities in Japan. They all plan to spend at least two years in Hawaii to complete their internship and medical training. The following is their bibliography: **Dr. Keiji Shimizu** who was born in Tokushima City, Japan, is a graduate of the Osaka University Medical School, 1940. He served in the Osaka University Hospital from 1949 to 1950; **Dr. Jiro Nakano** was born in Hiogo Prefecture, Japan, and is a graduate of the Hiogo Medical College, 1949. He interned previously at the Hiogo Medical College Hospital; **Dr. Nikiyo Kato** was born in Kobe, Japan, and is a graduate of the Okayama University Medical College in 1948, following which he interned at the Hiogo Medical College from 1948 to 1949. He served postgraduate training as an assistant in obstetrics and gynecology at the Hiogo Medical College and belongs to the Japan Obstetrics and Gynecology Society; **Dr. Mutsuo Miyaji** born in Tsu City, Mie Prefecture, Japan, is a graduate of the Kiyo Prefecture Medical University in 1950.

**Dr. George Hill Hodel**, of Los Angeles, has joined the Territorial Hospital, of Kaneohe, as an assistant psychiatrist to **Dr. Marcus Guensberg**, Medical Director. Dr. Hodel is a graduate of the University of California and has had many years of experience in public health work. He spent about eighteen months in China with a United Nations Mission and practiced psychiatry in Los Angeles before coming to Hawaii.

A recent wedding of considerable interest in local medical circles was that of **Dr. Elisabeth Madge Kehrer**, resident in pathology at The Queen's Hospital, to Mr. Page Morris Anderson, a local attorney. Other medics in the wedding party were **Dr. Etta Wright Best**, maid of honor, and **Dr. Carolyn Taylor**, one of the bridesmaids. Both are physicians at The Queen's Hospital. The best man was **Dr. Charles S. Judd, Jr.**, surgical resident at The Queen's Hospital.

**Dr. Masato M. Hasegawa**, a native of Wahiawa and Hilo, has recently joined **Dr. John T. Kometani** in the

Medical Arts Building, Honolulu, where he is specializing in pediatrics. Dr. Hasegawa has completed a year as chief resident at the Kapiolani Children's Hospital. His preliminary education was at the Hilo High School, following which he studied at the University of California, in Berkeley. His medical education included two years at the University of California and two years at Wayne University, in Detroit. His internship was at the City of Detroit Receiving Hospital. He trained in pediatrics at the Boston Children's Hospital for two years. During World War II he served in the 442nd Regimental Combat Team in Italy and later in the Army of Occupation in Korea.

**Dr. Richard You** has been elected 1951 president of the Kamaaina Magic Circle. Our congratulations to our prestidigitator friend.

Congratulations are extended to **Dr. and Mrs. Thomas S. Min**, who welcomed their second child, Janice, on November 20, 1950, at the Kapiolani Maternity and Gynecological Hospital.

**Dr. Yorio Wakatake** has returned from the mainland, where he served as a Fellow in the Department of Obstetrics and Gynecology at the College of Medical Evangelists Hospital in Los Angeles, California.

**Dr. Edmund Ing** was elected as an Associate Fellow in Urological Surgery by the International College of Surgeons. He also did a few months' postgraduate studies at the Cook County Hospital in Chicago, Illinois.

## Hawaii

### Welcome Home, Doc.

**Dr. and Mrs. Samuel R. Brown** finally returned to Hilo on February 1 after a 6 months vacation on the mainland. His locum tenens, **Dr. Fred I. Gilbert, Jr.**, returned to San Francisco to his instructorship at the Stanford University Medical School.

**Dr. and Mrs. R. P. Wipperman** returned to Hilo on February 5, 1951. Dr. Wipperman had been on an extended active duty at the Medical Field Service School, Ft. Sam Houston, Texas for 6 months.

### Hello, Doc.

**Dr. Robert B. Faus** of Honolulu paid Hilo a visit in December, 1950, and spoke to the medical society on Civil Defense, Selective Service, and HMSA.

In January, **Dr. Rogers Lee Hill** made his presidential visit to the Big Island. Along with him was **Dr. Richard C. Durant** of Honolulu, Chairman of the Public Service Committee.

**Dr. Raymond J. Kennedy** of Joliet, Illinois, while vacationing in the islands, stopped over in Hilo on February 6, 1951, to visit his former associate, **Dr. Robert Miyamoto**.

### First 100 Years Are The Hardest, Doc.

**Dr. Kay K. Ota**, who had been a locum tenens for a couple of local doctors within the past year, will venture into private practice of his own in Hilo in the near future. Dr. Ota attended University of South Dakota School of Medical Sciences for 2 years, then finished his clinical years at University of Kansas School of Medicine in 1948.



**PETER E. ARIOLI  
1915 - 1950**

Dr. Peter E. Arioli, of Hilo and Kamuela, was killed in action in the Changjin Reservoir Section, Korea, on December 3, 1950, while serving as a Naval Medical Lieutenant attached to the Marine Corps. Dr. Arioli was the son of the late Peter E. Arioli, Big Island engineer, contractor and businessman. He is survived by his mother, Mrs. Horatio B. Moore, of Kamuela and Berkeley, California, and by two brothers and a sister.

Dr. Arioli received his preliminary education at the Hilo High School and was graduated from Harvard University and Northwestern University Medical School. During World War II he served with the U. S. Naval Medical Corps attached to the Marine Corps and was a veteran of combat duty in the South Pacific. The JOURNAL extends its deepest sympathy to his family.

**Maui**

**Dr. Robert F. Cole** of Paia is building a home in East Maui.

**Dr. Jesse I. Knox, Jr.**, of Lanai City, is a new member of our Society.

**Dr. James F. Fleming** of Wailuku returned from his three months locum tenens work in India and is back at his office. He has been kept busy relating his interesting experiences in India to lay organizations.

**Dr. Edward Kushi** of Wailuku underwent a major abdominal operation at the Queen's Hospital. He is at present convalescing at his home.

**Dr. Sau Ki Wong** of Kaunakakai, Molokai, was married to Miss Paula Mitsuko Nakamura, R.N., of Kapaa, Kauai, on September 23, 1950, in Honolulu. After their honeymoon at the Volcano House and Kona Inn, they returned to Molokai where Dr. Wong is in private practice.

**Dr. and Mrs. William Toney** of Lahaina took a week-end plane trip on January 6-7 to Molokai to attend the charter night of the Molokai Chamber of Commerce. They were also the guests of **Dr. and Mrs. John I. Reppun** of Kaunakakai, Molokai, at the first anniversary celebration of the Molokai Community Hospital (formerly Shingle Memorial Hospital) of which Dr. Reppun is the medical superintendent. Dr. Toney is a director of the Maui Chamber of Commerce and of the Maui Community Chest.

**Dr. Theodore G. Lathrop**, accompanied by his wife and four children, recently arrived on Maui to become Maui County's new health officer. He is a graduate of the University of Wisconsin Medical School. He served five years as a county health officer of Klickitat County, Washington, and city health officer for White Salmon and Bingen, Washington.

Offices in Young Building, completely equipped for general practitioner, for sale or rent. For information phone 5-6893.

**NEWS**

**Honolulu Obstetrical and Gynecological Society**

Recent meetings of this society included papers on "Urological Disease in Gynecological Practice," by **Dr. James T. S. Wong**. Discussion of this paper was carried out by **Dr. S. Nishijima** and **Dr. C. C. McCorriston**. At another meeting **Dr. Madeleine A. Fallon**, of Los Angeles, presented a paper on "Rh Problems in Pregnancy and the Newborn."

**Honolulu Academy of General Practice**

**Dr. Richard K. C. Lee**, Assistant Director of the Territorial Department of Health, addressed this society on "The Board of Health and the General Practitioners."

**Honolulu Surgical Society**

The first meeting of the new year included the following scientific papers: "Surgical Diseases of the Thyroid," by **Dr. Harold S. Civin**, pathologist, of The Queen's Hospital. "Surgical Diseases of the Breast, with Particular Attention to Fibro-cystic Disease," by **Dr. I. L. Tilden**, pathologist, of The Clinic. **Dr. John Frazer** delivered an illustrated address on "Otosclerosis and the Fenestration Operation." A colored sound movie was shown on "Necropsy of an Elephant" with pertinent comments by **Dr. C. E. Fronk**.

**Polio Meeting**

The Second International Poliomyelitis Conference has been scheduled for September 3-7, 1951, at the Medicinsk-Anatomisk Institut of the University of Copenhagen in Copenhagen, Denmark, officials of the International Poliomyelitis Congress have announced.

Transportation and currency arrangements are being facilitated by Thomas Cook & Son, Wagon-Lits-Cook, and the American Express Company. Conference officials announced that the Swedish American Lines are making available the MS Stockholm, which is scheduled to leave New York on August 25th, and to arrive at Copenhagen on September 2nd.

Requests for hotel accommodations and information concerning the Conference may be obtained from the Secretariate of the Second International Poliomyelitis Conference, Statens Seruminstitut, 80 Amager Boulevard, Copenhagen 5, Denmark. The telegraphic address is Poliocon, Copenhagen.

The Honolulu Chapter of the National Foundation for Infantile Paralysis will consider providing financial assistance up to \$500 for one or \$1,000 for two local physicians who might be in the conference area and who are acceptable to the Chapter to act as delegates. Physicians who may find it possible to take advantage of this offer should contact the Executive Secretary of the local chapter at 810 North Vineyard Street, Honolulu 8-3945.

**Diagnostic Standards and Classification of Tuberculosis**

A new edition of this authoritative handbook on the diagnosis and classification of tuberculosis has been issued by the Local Tuberculosis and Health Associations of Hawaii.

Revised under the direction of the National Tuberculosis Association's medical section, the American Tru-

deau Society, this is the ninth edition of the book. It was first published in 1917 and was last revised in 1940.

The clinical classification of tuberculosis has been re-defined in the new edition, with such terms as "apparently cured" and "apparently arrested" abandoned in favor of "inactive" and "arrested," with the period of inactivity or arrest specified.

Chapters on rehabilitation and on mass X-ray screening surveys are included for the first time. The importance of the X-ray in fighting tuberculosis today is further emphasized by an enlargement of the section on the roentgenogram as a diagnostic aid.

The ATS committee, which worked for two years on the revision of the book, was headed by Dr. Ralph Horton of Homer Folks Hospital, Oneonta, N. Y. Chairmen of the subcommittees, which dealt with specific subjects covered in the book, were: Dr. C. Eugene Woodruff of Northville, Mich., evaluation of laboratory procedures; Dr. Joseph D. Aronson of Philadelphia, tuberculin testing, and Dr. Edgar M. Medlar of Sunmount, N. Y., pathology.

DIAGNOSTIC STANDARDS is made available to physicians, nurses and others by local Tuberculosis and Health Associations of Hawaii through Christmas Seal contributions.

**61st  
ANNUAL MEETING  
HAWAII TERRITORIAL MEDICAL ASSOCIATION  
HONOLULU, HAWAII  
MAY 3 - 4 - 5 - 6, 1951**

**OBSTETRICAL HEMORRHAGE**

Nicholson J. Eastman, M.D., of Baltimore, Professor of Obstetrics and Obstetrician-in-Chief, Johns Hopkins Hospital

**CYTOLOGICAL DIAGNOSIS IN OBSTETRICS AND GYNECOLOGY**

Herbert F. Traut, M.D., of San Francisco, Professor of Obstetrics and Gynecology and Obstetrician and Gynecologist-in-Chief, University of California Hospital

Also papers on the following subjects:

**ESTIMATION OF IMMEDIATE POSTPARTUM BLOOD LOSS**

**SYMPOSIUM ON ACTH AND CORTISONE**

**BUBONIC PLAGUE**

**COMMON ARRHYTHMIAS AND THEIR TREATMENT**

**DIFFERENTIAL DIAGNOSIS OF THE LYMPHOCYTOSES**

**REPORT OF THE CYTOLOGIC LABORATORY OF THE HAWAII CANCER SOCIETY**

**CHEMO-SURGERY AND PLASTIC SURGERY IN THE MANAGEMENT OF FACIAL CANCER**



# Hawaii Cancer Society Services to Physicians

*"Every doctor's office a cancer detection center!"*

Rather than setting up special cancer detection centers as has been done in some localities on the mainland, the Hawaii Cancer Society is working in full partnership with all physicians in making this slogan really effective in Hawaii.

One of the most important phases of the Society's program is to help physicians obtain the latest information on the diagnosis and treatment of cancer.

Since the beginning of 1950, the Society has been sending *The Cancer Bulletin* to every physician in the territory associated in any way with the problem of cancer. This bulletin, published bi-monthly under auspices of the M. D. Anderson Hospital for Cancer Research at the University of Texas, is considered the best of its kind in the United States. Various cancer societies in many states throughout the country send it to physicians in their areas.

The Hawaii Cancer Society also makes a yearly grant—\$500 this year—to the library of the Honolulu County Medical Society at the Mabel L. Smyth building for purchase of the latest books, journals, reprints and other materials on various aspects of cancer.

Another phase of the Cancer Society work is the bringing to Hawaii of world renowned authorities on cancer to speak to local professional men and women. Dr. George Pack was brought to the islands in the spring of 1949 for a series of lectures, and the Society plans to bring another speaker this year. Last fall, Miss Rosalie Peterson, cancer nursing specialist of the U. S. Public Health Service, was brought by the Society for meetings with nurses on the various islands. Several authorities passing through Honolulu have been made available to local physicians under auspices of the Society's professional education committee.

Still another activity of the Cancer Society is the financial assistance given to the tumor clinics at Queen's, St. Francis and Kuakini hospitals.

In cooperation with the Territorial Medical Association, the Hawaii Cancer Society operates a cytological laboratory service at the "Cancer Cottage" on Punchbowl St. between Beretania and Hotel Sts. The service was established following approval by the medical service committee of the Cancer Society and the cancer committee of the Territorial Medical Association. A technician was sent to the University of California for five months' intensive training, and following her return, the laboratory was opened July 25, 1949 to give service free of charge to physicians on all islands.

An increasing number of physicians has been using the services of the laboratory during the year and a half of its operation.

In its public education program as well, the Society works in cooperation with physicians, who are used as often as possible as speakers before lay groups because of the authority with which they can speak. The Society expresses its gratitude to physicians for the time and interest given to cooperation with this program.

In its public education program, the Society makes a careful effort to avoid the use of any educational material which might have an alarming effect. Together with representatives of the Medical Association and the Territorial Department of Health, it pre-views films considered for local use, and in a number of cases has returned to the mainland films which are considered undesirable from a psychological or emotional viewpoint, as well as those not measuring up to medical standards. The Society is continually testing its public education program to determine its effectiveness and to ascertain whether "cancerophobia" is developing from any of its activities. The Society urges physicians to report any case of undue apprehension about cancer which comes to their attention and can be traced to the Society's educational program.

**McARTHUR & SUMMERS****PRESCRIPTION • PHARMACISTS**PHONES 6-6044  
6-8865THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAIIEMERGENCY PHONES  
7-5419 • 7-8411***WE THANK YOU!***

On March 1st we celebrated our  
**TENTH ANNIVERSARY**  
as your Prescription Pharmacists

**Our Prescription Files Show****Over 325,000 Tokens of****PHYSICIANS' CONFIDENCE****AND****PATIENTS' TRUST*****AGAIN,******WE THANK YOU!*****McARTHUR & SUMMERS****PRESCRIPTION • PHARMACISTS**PHONES 6-6044  
6-8865THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAIIEMERGENCY PHONES  
7-5419 • 7-8411

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

---

## BULLETIN COMMITTEE

ANGELA M. CARLUCCI, *Editor*, Leahi Hospital, Honolulu  
LAURA DRAPER, *Nursing Information Committee*, Board of Health, Honolulu  
LEAH BIGELOW, *Nursing Information Committee*, St. Francis Hospital, Honolulu  
MABELCLAIRE NORMAN, *Executive Secretary*, Honolulu  
ALISON MCBRIDE, *Territorial Association Secretary*, Honolulu

### *Secretaries*

BESS HAMMER, Hawaii  
VIRGINIA RAUTENBERG, Honolulu  
PAULINE JOHNSON, Kauai  
LAURA WONG, Maui

### *Publicity Chairmen*

GRACE LUSBY, Hawaii  
HELEN GAGE, Kauai  
MICHIE KAMITAKI, Maui

---

## IMPRESSIONS OF A MALIHINI

LEONA ADAM, R.N.\*

Because in the school geographies the Sandwich Islands are a small dot on a very large ocean many mainlanders have no appreciation of their size, the amount of scientifically grown produce, and the numerous problems of the many peoples.

Here on Oahu we have two long mountain ranges so sharp as to seem cut from cardboard but softened by the green growing to the tops and always clouds billowing above. An island cut by two ranges but with expanses of scientifically planted pineapple fields—and have you had a plant-ripened fruit handed to you by the field worker whom you watched slice off the outside with four sharp strokes? Food for the gods! Then, in another area, field after field of sugar cane in all stages of growth. Research on the island has made sugar an important export! On around the island we find the banana and papaya fields and the plateaus of taro fields—how can all this grow on such a little spot! And have you ever slid around under the banana fronds in the “grease slick” mud behind a friendly helpful woman who “knew” that the sought for family lived “just around the corner”? “What corner?” I said. So off she started in her bare feet, swinging from banana tree to banana tree with me sloshing through the mud behind her. If you haven’t tried it bring your skis and spend a rainy day with me—never a dull moment! Or, have you seen the huge water buffalo pulling a plow

through a flooded field preparing for the next taro crop?

If ever car TH 237 becomes involved in an accident the chances will be that the driver was craning her neck to get a better view of the cup of gold, or those wonderful poinsettias growing at every door (at home a plant with three flowers is eight to ten dollars)! Or, to see another rainbow—high in the sky; at the foot of the mountain; or—one day as I turned at the top of the Pali there stood a rainbow on end in the valley—like a many colored pillar! I’m told they appear in circles also, but that I will have to see! Or again, on a rainy, windy day one must see the upside down waterfall. Wonders never cease!

Becoming more prosaic—or shall we say practical—the health and safety work being done here is constantly amazing to me. The well trained school safety patrols, the courtesy of drivers to pedestrians and to other drivers. The tuberculosis control program, not just words on paper, but a program extensively and intensively carried out—the results of which are demonstrated statistically. The intensive work done with crippled children. The acceptance by workers of people as they are without attempting to impose mainland standards upon them. The maternal and child health clinics with their educational opportunities. Then—the Department of Health importing and releasing mosquitoes to eat other mosquitoes! It’s all out of this world!

Above and beyond all these there are four things which have particularly impressed me; first, the closeness of all health and welfare workers—the social worker, the school counsellor, the gov-

\* Miss Adam, a recent addition to the Bureau of Public Health Nursing, received her nursing certificate from Western Reserve University, served as president of the Indiana State Nurses' Association and was formerly public health nurse coordinator at St. Vincent's Hospital School of Nursing, Indianapolis, Indiana.



ernment physician, the family physician, the hospital worker, the public health nurse. Everyone seems to feel free to call upon the other for help and there is a sharing of responsibilities and findings.

Second, the excellent educational opportunities for the public health nurses through planned programs of lectures, conferences with consultants, and field trips which are so essential in keeping us all up to date and informed about our community.

Third, the outstanding efforts of the nutrition division of the Department of Health toward helping the people of Hawaii to have adequate diets based on their racial customs and the produce of the islands.

Fourth, my last two years on the mainland were spent, in part, in attempting to establish a referral system in an up and coming hospital so that the patients might have a comprehensive nursing service. When I left there was still much to be done. Here we find a simple plan for referral of patients to any agency, which is almost common practice! Hospitals refer patients to the public health nurse for follow-up almost as a matter of course. It is all most amazing—but gratifying.

Job satisfactions have come quickly—a para five always delivered by a midwife coming in for her first postpartum examination; a young man x-rayed who for two years had ignored the pleas of the public health nurse; a family budget helped because the nutritionist demonstrated to a mother that she could save one hundred and fifty-two dollars a year by using evaporated instead of fresh milk!

If in four short months all these things have been discovered—what will the next year bring!

## MONEY MANAGEMENT FOR NURSES

MARJORIE ABEL\*

When this subject was suggested, the first reaction was, "If nurses need to know about money management, so do all people." With rising taxes and the rising cost of living, many individuals and families are having a very difficult time to adjust. We must use better management, if we are to live within our incomes at all.

Some items are fixed. Perhaps, it may be best go down the list and discuss each item which seems necessary in modern living. A committee on Minimum Content of Living reported to the Honolulu Council of Social Agencies that the basic requirements considered essential were as follows:

1. Food
2. Shelter
3. Clothing, upkeep and personal care
4. Utilities, including telephone
5. Household supplies and equipment
6. Transportation
7. Community activities and recreation.

Other items are taxes, medical and dental care, education, and insurance and savings.

Some of these items are fairly well fixed. Taxes, rent, necessary transportation, are things you can do very little about. The old rule in budgeting was: One week's income for rent. That is often an impossibility today. You pay what you have to and adjust.

Taxes, in the days when budget rules were pontificated with certainty, were a minor matter. Today, they consume at least a third of the income if you include all the sales taxes and hidden taxes. Like death, they are a certainty.

A telephone is probably a necessity for a nurse if she has her own home. There is a slight saving in a party line, which is not too inconvenient.

The cost of utilities can be controlled to an amazing extent by turning off lights when not in use; turning down the heat on the stove as soon as the pot is boiling and turning it off entirely to finish. A pressure saucepan may pay for itself in fuel savings, if much cooking is done.

Household supplies and equipment expenditures depend largely on whether the home is furnished and how much housekeeping is done. Care to prevent waste and care in upkeep can cut expenses here.

Community activities and recreations can be a heavy expense or not. The cost of recreation can be cut. As for community activities, some are fixed charges because this would include dues to professional organizations, church donations and so on.

Clothing is one item where there is considerable choice. In a tight budget, there is little room for novelty gadgets. Conservative, well-chosen clothes of good material, carefully cared for, will go a long way toward cutting costs. Considerable money can be saved if clothes can be made at home. Personal taste and the exigencies of the job control the choice somewhat. When the job necessitates meeting the public, it may be necessary to spend more on clothes. The planned wardrobe is helpful. Dresses, suits and separates should be planned so that one set of accessories will complete them all. For example, a brown bag, one pair of brown day shoes and one of brown dress shoes will do for a wardrobe planned with browns, greens and yellows. A red bag and shoes can complete several costumes.

\* Chief, Bureau of Nutrition, Terr. of Hawaii Dept. of Health.

Insurance and savings often seem impossible, yet are as often essential. There is a sense of futility about annuities and savings when the dollar keeps having less and less value. A dollar saved twenty years ago bought a dollar's worth of goods. Today, that dollar will buy about half as much. And who can predict the future? However, some form of medical and accident insurance seems necessary to take care of emergencies.

Food has been left to the last, possibly because many people start economizing here. This is a good place to economize but never to the extent of inadequate diet. Health may not deteriorate if the food is inadequate for short periods but any economies started now may have to continue for a considerable period. Lack of energy, reduced resistance to infection, changes of personality, vague malaise, may all result from inadequate diets. Any of these may increase medical bills and interfere with proper conduct of your job.

It is possible to reduce food costs a good deal and still keep the nutritive value of the diet. Food habits may have to change but this can be done if the need is recognized. Inexpensive food can meet Dr. Henry C. Sherman's criteria of meals that:

1. Look and taste appetizing,
2. Fit the family budget,
3. Provide the proper number of calories,
4. Provide the basic food elements—proteins, fats, carbohydrates, vitamins and minerals.

The day's meals should be planned to include the Basic 7 Food Groups. Choice of the less expensive foods in each group may even increase food value. As an example, a serving of orange juice will cost at least twice as much as a serving of papaya which has twice as much vitamin C. Margarine is exactly as valuable as butter, at a saving of 50 cents a pound. Non-fat milk solids give all the most important values of milk at less than half the cost. Beef liver has a higher nutritive value than calves' liver and is always less expensive. These are just a few possible savings. It is possible to feed a woman, living with two or three other people, under \$30 a month. There are few steaks and chops in such a budget; however, the meals can be good to eat as well as good for you and your budget.

These are what seem like the necessities of modern living. Gifts, books and travel are not considered essential but certainly contribute to mental hygiene. And, if your experience is like that of the committee mentioned earlier, when you add all these items, your total is impossible and you have to start cutting again.

## EDITORIAL

"In unity there is strength" is a most familiar quotation. The driving force of an individual with definite goals in mind can be effective only when this force is combined with the strong support of many other individuals striving toward the same goals.\*

Many nurses may today seem unhappy with their lot. Perhaps many of the common complaints are justified but it takes more than one individual to effect a change in these things.

"We have such a group—well known to us as the American Nurses' Association. It has been through this organization and its active membership that nurses are permitted to enjoy fuller lives than they were twenty years ago.

"Why should you be a member? What have the nursing organizations accomplished?"\*

If it were not for our nursing organizations, we might have no laws to protect the public from an unskilled impostor who wanted to call herself a nurse.

If it were not for our nursing organizations, we might have no state regulation of schools of nursing, and students might still be exploited, overworked, and inadequately prepared for their responsibilities as graduates.

If it were not for our nursing organizations, private duty nurses might still be on duty 20 hours daily, and sleeping on cots in patients' rooms.

If it were not for our nursing organizations, we might have no opportunities for graduate nurses to receive advanced education in universities and colleges.

If we had no nursing organizations, there would be no Biennial, no state convention, no district meetings, and no institutes to keep nurses up to date and informed.

If it were not for the eternal vigilance of the legislative committees of our nursing organizations, nursing courses might be shortened, hospital corpsmen might have been allowed to register without any real nursing education, graduates of correspondence schools might be recognized, and dozens of other proposed laws might have been passed to the detriment of the professional nurse.

If it had not been for the nursing organizations, nurses might have been drafted in the recent war, standards in schools might have been seriously lowered, and federal funds might have been administered under political patronage.

If the nursing organizations had not conscientiously labored to raise the nurse to a professional level, nurses might still be regarded as a sort of maid-servant, instead of enjoying the respect and admiration of the public.

If it had not been for the vigorous stand on the economic problems of nurses, many institutions would still be paying niggardly salaries for long hours of work.

If it were not for our nursing organizations, we might have no Registries, no *American Journal of*

\* The American Nurses' Association Membership Manual.



*Nursing*, no Professional Counseling and Placement Service, no Headquarters, no assistance to schools in recruiting students, or the many other programs to help nurses everywhere.

Nurses may continue to bemoan their lot and may always do so, for it seems the nature of humans to always want something better.

In the Territory there are 1,700 nurses, of whom only 643 are members of the Association. Monthly, well planned programs are held and and poorly attended. Committees exist to cover all aspects of progressive nursing but it appears the same individuals serve on each one.

Why is membership so low?

Why must the same individuals serve so intensely? I cannot answer for you. However, I can urge that each one of us obtain one or more members from the large group of non-ANA's. Every nurse is needed, and there are 1,057 memberships to be obtained.

### SHARE IN RED CROSS PROGRAM

LORETTA SCHULER, R.N.\*

Nurses have an opportunity to share in the maintenance of community health by enrolling with the Red Cross to serve as home nursing instructors.

Training courses provided for potential instructors give supervisory assistance and help insure a more uniform course content as well as a high quality of teaching. The training method used is designed to help instructors teach simple nursing skills as safely, quickly, and effectively as possible. The home nursing instructor training course, based on accepted principles of teaching and learning, may be taken individually or in groups, and in a chapter teaching center or at a university. The instructor training course consists of two parts:

1. The period of intensive instruction (36 hours), in which a training supervisor demonstrates and interprets the content and method of the course to be taught and the instructors-in-training return the demonstrations, each of them teaching assigned parts of the lesson. An explanation of the educational principles involved and an evaluation of the students' ability to use them follows.
2. The period of supervised practice teaching, during which each instructor-in-training teaches under supervision a six-lesson course in home nursing.

The instructor training courses are conducted by specially trained supervisors authorized by the area office.

Completion of the training course is required for those who plan to teach Care of the Sick, Unit

I, and Mother and Baby Care and Family Health, Unit II. It is recommended, however, for those who plan to teach any Red Cross Home Nursing course.

Nurses no longer active in the profession—housewives, or retired nurses—may continue their contribution to the community, as well as keep in touch with nursing information, problems, and skills, through enrollment with the Red Cross. They will take pride in lending their skills to meet special community needs and thus hold responsible places as thinking and "doing" citizens. In retraining for or maintaining nursing skills, the nonpracticing nurse can help our nation maintain the potential nurse reserve at a high level of effectiveness so that in case of national or regional emergency this inactive professional group can be effectively integrated into the total pattern for action and return to full-time or part-time nursing on a paid basis.\*

#### DEAR RED CROSS NURSE:

As an enrolled Red Cross nurse with specialized skills and experiences, you are an important part of your chapter's civil defense resources. With such prized professional equipment, we feel sure you will want to continue to assist your chapter in meeting the welfare and health needs of your community.

So that the nurse enrollment committee may call upon you when you are needed and available, certain information is essential for the chapter to have—who you are, where you are, what your main interests are, and when you may be available. If you are a mainland nurse now residing in the islands, or a local nurse, and have not contacted Hawaii Chapter since June 1950, will you be good enough to call the Nursing Services Department and indicate availability for one of the following Red Cross programs: disaster, home nursing, volunteer nurse's aide, or blood program.

Even though you may not be available for some activity at the present time it would be appreciated if you will indicate your interest for future participation.

LORETTA T. SCHULER  
Director, Nursing Services  
Hawaii Chapter, A.R.C.

#### FROM YOUR LOCAL HEADQUARTERS

Many times we are all asked, "What does the Nurses' Association do?" "What has it ever done for me?" That isn't a difficult question to answer, for the association of which you are a member has done much for you. How do you suppose that the eight hour day came about? Surely not of its own accord or because one or two nurses desired it. How do you suppose the increasingly higher wage scale came about? Who helped raise the standards of the nurse's work until now nursing is considered a profession? Only through unity has all this been attained, and in unity there is

\* For more detailed information, contact Miss Loretta Schuler, Director of Nursing Service, Hawaii Chapter, American Red Cross, Honolulu, T. H.



strength. Several nurses have been heard to remark that when the association obtained a 40 hour week for them they would join. Needless to say this needs no comment. If we will all work together to attain the objectives we have set before ourselves—furthering an economic security program, we will accomplish this. In these unsettled times, none of us knows what the next day will bring, but we can at least have faith enough in God to try to plan for a future which may not be as unsettled. It may seem a fruitless task at this moment to try to attain an economic security program, but insofar as it is possible, your officers and board of directors are pledged to do as much as they can for all.

I do hope that all of you have read the very interesting article in the January 1951 issue of the AJN called 1950 Roundup. If you have ever had any doubts as to what the American Nurses' Association has been doing and plans to do, this will surely make it all clear to you. You all ought to be mighty proud to be a member of such an active and worthwhile organization. No nurse who thinks at all well of her work, could possibly want to stay out of her own organization. Here is an unexcelled chance for professional growth and advancement. Who wants to stagnate in this rapidly changing world? You wouldn't think of wearing the type of clothes you wore in 1930—they're out of date. Don't be out of date in your profession—keep up with the times and keep in step with the times. Just paying your dues doesn't gain you a thing—take part in the organization: attend meetings, serve on committees. Then you will find that you receive untold benefits that you cannot count in terms of money or material. Use some of these arguments if you will on those members of the nursing profession who have yet to join the ranks of the 171,000 members of the ANA.

There have been a few changes in the organization of the staff here in your headquarters office. Mrs. MacQueen is now employed only by the Board for the Licensing of Nurses and the District of Oahu. Mrs. Grace Page joined the staff as half-time secretary-stenographer on January 8, 1951. Mrs. Illa Storme has been designated as Registrar of the Nursing Service Bureau and Physician's Exchange.

Do you realize that we have some 1700 licensed professional nurses who are actually here in the islands and yet last year, this association only had a membership of 643? I think we can do better than that this year. We can do it if we will!

MABELCLAIRE NORMAN, R.N.  
Executive Secretary

## NEW OFFICERS IN DISTRICTS

In January, all the districts held their annual meetings and many new officers were elected. The officers for each district are:

### District of Oahu

President.....	Mrs. Esther Stubblefield
1st Vice President.....	Miss Mary V. Cheek
2nd Vice President.....	Miss Elvira Hamilton
Secretary.....	Mrs. Virginia Rautenberg
Treasurer.....	Miss Alice Shida
	Mildred Asato
	Virginia Ahrendt
Directors.....	Ethel Hass
	Hannah Richards
	Alice Scott

### District of Hawaii

President.....	Mrs. Mae Marcallino
1st Vice President.....	Mrs. Edna Baldwin
2nd Vice President.....	Mrs. Elizabeth Stillman
Secretary.....	Miss Margaret Barnett
Treasurer.....	Miss Sumiko Kumabe
	Mrs. Nettie Marimoto
	Miss Violet Yamashira
Directors.....	Miss Beth Hammer
	Miss Eunice Graham

### District of Kauai

President.....	Miss Elizabeth Middleton
1st Vice President.....	Miss Thelma Hensley
2nd Vice President.....	Mrs. Helen Gage
Secretary.....	Mrs. Pauline Johnson
Treasurer.....	Mrs. Grace Furugen
	Mrs. Miyaka Masunaga
	Miss Alice Tanaka
Directors.....	Mrs. Cella Cackett
	Mrs. Clara Chalmers

### District of Maui

President.....	H. Eileen MacHenry
Vice President.....	Gloria Foster
Treasurer.....	Miriam Schmidling
Recording Secretary.....	Laura D. Wong
Corresponding Secretary.....	Suzanne Bisset
	Judy Sakamoto
	Hilda Yatsushiro
Directors.....	Edith Kishimoto
	Isabel Chung
	Iania Rickey
	Ann Gillin

## NEW OFFICERS

### LEAGUE OF NURSING EDUCATION

Following are the names of the officers of the Hawaii League of Nursing Education. President, **Alison MacBride**; Vice President, **Mary V. Cheek**; Secretary, **Mrs. Rosie K. Chang**; Treasurer, **Loretta Schuler**; Directors, **Sister Mary Albert**, **Mrs. Arlene Thompson**, **Mrs. Dora-thea McClintic**.

### OAHU PUBLIC HEALTH NURSES ORGANIZE

On November 29, 1950, a group of public health nurses met at Mabel Smyth Auditorium for the purpose of organizing a Public Health Nursing Section of the City and County Nurses' Association. The following were elected to office for the coming year:

Chairman.....	<b>Alma Whitman</b>
1st Vice Chairman.....	<b>Jane Oki</b>
2nd Vice Chairman.....	<b>Natsuko Kubo</b>
Secretary .....	<b>Daisy Morita</b>

Membership is close to the fifty mark!

## THE RELATION OF THE AMERICAN NURSES' ASSOCIATION RESEARCH IN FUNCTIONS TO THE PRESENT SURVEY OF NURSING RESOURCES IN HAWAII

ALISON MACBRIDE, R.N.\*

At our last annual meeting our membership voted to give financial support to the research plan "Studies on Nursing Function" which the American Nurses' Association proposes to direct and coordinate in selected states. The findings of such research should answer some fundamental questions about present day nursing practice in the United States which can be stated as: What are the differences in the functions being performed by the professional nurse and the non-professional nurse? What functions, formerly considered medical practice, are now considered nursing practice? How does present use define the areas of practice and responsibility for each member of the health team concerned with patient care? Most perplexing problems, these; and we in Hawaii would like the answers; so would nursing educators, who badly need these answers to prepare competent nurses in educational programs throughout the land.

Our members were so exercised on this matter in the 1949 meeting that we voted to attempt some local research on functions and relationships on the health team. A committee was appointed to study the possibility of doing such research in Hawaii. Early in 1950 the American Nurses' Association adopted a policy to coordinate and direct research on these problems. Then we voted to support the American Nurses' Association research plan and have asked that Hawaii be considered as the locale for one of their pilot studies. If the American Nurses' Association selects Hawaii we will need a nurse trained in research to direct the project.

The present survey of our nursing resources and needs in Hawaii, which was completed in March, does not duplicate research into nursing functions. The Board for Licensing Nurses appropriated \$3000 for this survey and the cost of bringing Ruth Gillan, Nurse Consultant in the Division of Nursing Resources, Public Health Service, to the islands this February to work with the Nursing

Study Committee. Nurses' Association, Territory of Hawaii, and the League were instrumental in having the Legislative Holdover Committee of 1949 appoint a Nursing Study Committee to conduct the survey and work with Miss Gillan. The scope of the survey is to estimate the nursing manpower available in the Territory, the nursing personnel currently employed, and the personnel needed to meet current and future needs, and to evaluate the quantitative and qualitative adequacy of the present system of nursing education in the islands. Survey findings will lead to recommendations concerning the extent to which the nursing service needs of all kinds should and can be met; the kind of educational system which will produce the type of nursing personnel needed; the methods of financing this educational system; and what community and territorial action is necessary to implement survey recommendations. Each county nurses association, and Medical Advisory Committee to the Holdover Committee, has representation on this Nursing Study Committee. The information about nursing was collected and summarized by the Technical Subcommittees before Miss Gillan's arrival. She visited hospitals and employers of nurses throughout the Territory to help the committee give proper and accurate interpretation to the survey data.

One very definite step you can take is to let your legislator know that *you* want *him* to see that the Joint Resolution Creating a Commission on Nursing Education goes through early in the coming session. Mr. Sakakihara, chairman of the Holdover Committee of 1949, believes such a Commission is needed to follow up on the Nursing Study recommendations.

## NATH PRESIDENT AT ANA MEETING ARLENE N. THOMPSON, R.N.\*

In my career as a professional nurse, I have had many wonderful experiences. My recent trip to New York City to attend the Advisory Council of the ANA was one of those valuable occasions.

Representatives from all the states, Puerto Rico, and Hawaii were present for this two-day conference. Mrs. Elizabeth Porter was a most gracious presiding officer. She carried the meetings through many tense moments.

Representatives from the Armed Services were present to state their immediate needs as to nurse recruitment. Following a lively discussion of ways to meet the state quotas, the question of drafting nurses was presented. As representatives were not

\* Educational and Assistant Director of Bureau of Public Health Nursing.

\* Nursing Director, Children's Hospital.



prepared to answer this question for their state groups, the council gave their opinion that at present drafting of nurses should not be considered. Each state was asked to obtain the opinion of their group concerning this matter. States were also urged to reactivate their inactive nurses.

Much disappointment and concern was expressed when we suddenly learned that the Bolton Bill, HR 910, died before it reached the House Committee. We were informed that the Omnibus Health Bill S 337 and Companion Bill HR 1781 would be presented to the full Senate Committee. As this bill does not meet the needs of nursing education as completely, all nurses were urged to contact their Senators. Nurses must be alert to the contents of these bills. It is hoped that a companion bill to the Bolton Bill will be presented to the Senate.

The Economic Security Program is moving forward in a steady pace. A workshop will be given in the late spring or early summer for assistance in planning the program on the state level. It is extremely important that a representative from Hawaii attend this workshop.

Open house and a lovely tea was given for the members at our new headquarters at 2 Park Avenue. As mail is received from ANA and the Journal of Nursing, etc., it will mean more to me for having had the privilege of visiting these offices.

## YOU WOULD ENJOY . . .

*The American Journal of Nursing* 50th Anniversary Issue, October, 1950.

"Make Mine Old-Fashioned" by Virginia Taylor Klose, in *McCall's* for November.

"The Social Impact of Television" by Frank Riley and James A. Peterson in *The Survey* of November.

"The Workshop at Work for Legislation" by Pauline S. Riley in *The American Journal of Nursing* for November.

"The Government's Plan for Drafting Women" by William Bradford Huie in *Cosmopolitan* for November.

"Getting Nurses Out To Meetings" by Bethel McGrath, R.N., in *The American Journal of Nursing* for September.

"When Disaster Struck—We Were Prepared" by Anthony W. Eckert and David Riddell in *Hospitals* for September.

"Annals of Medicine: The Fog" by Berton Roueche in *The New Yorker* for September 30, 1950.

"The International Council of Nurses: A World Force In Nursing" by Florence H. M. Emory in *The Canadian Nurse* for September.

"Don't Drive Without a Mental License!" by Edith Roberts in *Coronet* for October.

"Paternalism In Employer-Employee Relationships" by Harold L. Sheppard, Ph.D., and Audrey P. Sheppard, M.A., in *The American Journal of Nursing*, January, 1951.

## STUDENT RECRUITMENT

The Hawaii League of Nursing Education sponsors a plan to help guide young women in choosing a career in nursing.

Each year, the League appoints representatives from the professional schools of nursing to make trips to other islands for the purpose of discussing the opportunities in nursing with the high school students.

Information is given the students concerning the essential qualifications for them to enter the profession of nursing, the requirements and opportunities in the local schools, the procedure in making applications.

This year, Sister Mary Albert, Director of Nursing at St. Francis Hospital, visited the schools on Hawaii during the week of January 22. Mrs. Rosie Chang, Assistant Director of Nursing at Queen's Hospital, visited Kauai on January 25 and 26. Miss Mary Cheek, Director of Nursing at The Queen's Hospital, visited Maui, Lanai and Molokai during the week of January 29.

All students entering the local schools of nursing are required to take pre-nursing examinations. Dates on which these tests will be given may be obtained from the school principals on the various islands.

## PATTERN

(Author Unknown)

We're each of us a dreamer—  
And though some dreams come true,  
Some never seem to rise above  
The hopes they're anchored to.

But for each one of us a part  
In this world God has planned—  
It may be mine to simply clasp  
A little baby's hand.

And try to guide its faltering steps,  
It may be yours to lend  
A bit of courage, smile of hope,  
To some bewildered friend.

In this great drama we call "Life,"  
Our roles to us seem staid—  
The curtain falls—we never know  
How great a part we played.

Not all of us great things can do—  
Life does not all endow;  
But small things in a great way—yes:  
And love will show us how.

## HOBBY CORNER

Bird Hikes

LAURA A. DRAPER, R.N.\*

It was November when I left Minnesota for my new job in the islands, and as we flew over the bleak countryside, I thought of the brilliant birds I would soon see flashing through the tropical foliage of Hawaii.

Well, the cardinals did their best and the doves sounded very strange, and it was interesting to know that some mynahs could talk! After that, things were

\* Director, Bureau of Public Health Nursing, Department of Health.



so absorbing that I forgot about the exotic birds until the day when Myrna Campbell invited me to go on a hike with the Audubon Society.

As a matter of fact, it was the hike that was the attraction, and since that time, I have enjoyed a number of new and beautiful trails. Audubon Society members are companionable people. You go at your own pace and nothing could taste better than the cold water and cookies that Grenvill Hatch dispenses when we get back to the automobiles.

But to return to the birds; there are more in the forest than you would think. At any rate, my more informed associates give different names to the birds that fly past at a distance. I am particularly fond of two birds for I always recognize them. They are shore birds, large, comparatively stationary and out in the open. One is my idea of a small heron with red legs. It is called a stilt. The other is a galinule. He swims around looking to me like a duck, but when he turns his face toward you, it is as though a neon light goes on. That is the sun hitting his fantastically red face.

The bird hikers meet at the public library at 8:00 a.m. on the second Sunday in the month and are usually back in town by 4:00 p.m. Better watch for a notice in the newspaper. And if you start merely going for one innocuous hike, you may eventually find yourself, as I did, out in Bellows Field on the stormy day before New Year's, participating in the Audubon Society's nationwide bird count. It was rainy and windy and the birds stayed undercover in large numbers, but even so, it was fun.

## HOSPITAL HI-LITES

### HAWAII

#### Hilo Memorial Hospital, Hilo, Hawaii

New members added to the Staff:

(Mrs.) **Jane M. Geiger**, Director of Nurses: Graduate of Toledo State Hospital; Instructor and Organizer of Educational Programs in the Toledo, Ohio area; Clinical Instructor and Student Counselor at Riverside Hospital, Toledo, Ohio; Director of Education, The Veterans Administration; Director of Nurses at Pennsylvania, Detroit, and Delaware. Mrs. Geiger came to the islands from Delaware although her home is in Detroit, Michigan.

(Mrs.) **Kiyoko Ota**, Staff Nurse: Graduate of St. Helena Sanitarium and Hospital, California, and New England Sanitarium and Hospital, Melrose, Massachusetts. Mrs. Ota was formerly a resident of San Francisco, California.

(Miss) **Angela H. Goya**, Staff Nurse: Graduate of St. Francis Hospital School of Nursing. Took up post-graduate course at Cook County Hospital of Chicago, Illinois. Miss Goya was born in Hilo, Hawaii.

(Miss) **Sylvia M. Mitchell**, Staff Nurse: Graduate of Good Samaritan Hospital, Phoenix, Arizona. Miss Mitchell came to the islands from Bakersfield, California.

(Miss) **Inez T. Nelson**, Staff Nurse: Graduate of Abbott School of Nursing, Minneapolis, Minnesota. Miss Nelson came to the islands from Bakersfield, California. Her home town is in Coulee, North Dakota.

A new Central Supply has been opened allowing a great deal more space with many improved procedures. A complete reorganization of the obstetrical program is in progress. A new procedure book and ward manual

is being compiled. This is a beginning of reorganizing and revising of all the units in the nursing department. We are again assisting in the Gray Lady Program and hope to go on to the Nurses' Aide in an attempt to assist the disaster committee and prepare the women of the island.

**Miss Sumiko Kumabe**, Chief Nurse, is at present in Honolulu on a leave of absence because of her father's illness, who is confined at the Queen's Hospital.

#### Pepeekeo Hospital, Pepeekeo, Hawaii

Pepeekeo Hospital was officially closed on January 1, 1951, and an Out-Patient Clinic now serves the people of this district, with all patients needing hospitalization being sent to Hilo Memorial Hospital. **Mrs. Edna Baldwin** is Head Nurse and **Miss Irene Riley** is Assisting and Visiting Nurse.

### KAUAI

#### Mahelona Hospital, Kapaa, Kauai

Construction of the new hospital building is making good progress. The nurses are now living very happily in the new and sumptuously decorated modern building which faces the ever beautiful Pacific.

#### Waimea Hospital, Waimea, Kauai

**Miss Kay Seto** recently became **Mrs. Robert Onzuka**. Our very best wishes. . .

### LANAI

#### Lanai City Hospital, Lanai City, Lanai

**Miss Marjorie F. McRae**, of the Lanai City Hospital, left on the 15th of December for a five week vacation on the mainland. She visited with her family and friends in Alberta, Canada. Miss McRae has been a nurse at the Lanai City Hospital for one year. She returned to Lanai on January 22, 1951.

### MAUI

The Maui District Nurses' Association held its annual meeting at Club El Amigo in Wailuku on January 18. Chicken hekka was served and the nurses enjoyed adding the finishing touches to the main dish as it cooked.

The new officers and board members installed were: President, **H. Eileen McHenry**; Corresponding Secretary, **Suzanne Bisset**; Treasurer, **Miriam Schmidling**; Board Members, **Edith Kishimoto**, **Judy Sakamoto**, **Ann Gillin**, **Isabelle Chung**, **Ionia Rickey**, **Hilda Yatsushiro**.

Vice-President **Gloria Foster** and Secretary **Laura Wong** will serve for another year.

Outgoing officers were: **Elizabeth S. McCall**, who had served as President for four years; **Hinayo Ikeda**, Treasurer, and the following Board Members: **Beatrice Fujimoto**, **Elizabeth Morishige**, **Margaret Kinney** and **Modersta Singlehurst**.

Lovely hybrid orchid corsages were presented to each of the incoming and outgoing officers and board members.

#### News Items:

Five new members have joined the staff of Public Health Nursing for the Department of Health. They are: **Jo Ann Groburg**, **Rosemary Biss**, **Hideko Nishihira**, **Eileen Tsuchiya** and **Bernadette Couture**, who has been assigned to Molokai.

**Marion Wright** has joined the staff at Pioneer Mill Hospital in Lahaina. Marion served as camp nurse with the Girl Scouts at Camp Maluhia during the summer.

**Margaret Dahl, Jean Ogle** and **Ruth Thompson** have joined the nursing staff at Kula Sanatorium. These girls were originally employed in Mt. Edgecomb, Alaska.

**Elizabeth Sheridan**, Superintendent of Nurses at Kula Sanatorium, recently became **Mrs. Clifford S. McCall, Jr.**

**Margaret Alexander** was named Assistant Supervisor for the Bureau of Public Health Nursing, Department of Health, Wailuku.

**H. Eileen McHenry**, new President for the Maui District Nurses' Association, is very active in community affairs. In addition to her supervisory position at Haliimaile Dispensary, she is a Girl Scout leader, has a University Extension group and is active in the Business and Professional Women's Club. In her "spare time" she does wood carving and plays a little golf.

**OAHU**

**Kauikeolani Children's Hospital, Honolulu, T. H.**

**Mrs. Arlene Thompson**, Director of Nurses and President of the Territorial Nurses' Association, attended the Advisory Council of the American Nurses' Association in New York City, January 22 and 23.

Recent new staff members are **Arlene Grundahl**, Graduate of St. Michaels Hospital, North Dakota; **Jeanette Seo**, St. Francis Hospital, Honolulu; **Margaret Ballew**, Grace Hospital, Windsor, Canada; **Clare Umemata**, Kuakini Hospital, Honolulu.

We are happy to have two of our former staff members return: **Ruth Furukawa**, Queen's Hospital, Honolulu, and **Miyo Akazawa**, St. Francis Hospital, Honolulu.

**Margaret Szmyd**, a graduate of St. Claris Mercy Hospital, Newfoundland, has been relieving in our surgery for vacation periods.

**Irene Snyder** returned January 15 from her vacation on the mainland. She visited her parents in Harlan, Iowa.

Wedding Bells rang recently for **Cecelia Donahae** and **Vernon Anderson**; **Evangeline Simpson** and **Ellis W. Cook**.

Nurses participating in Red Cross activities are **Miss June Apa** and **Mrs. Irene Zane**.

During her recent trip to New York City, **Mrs. Arlene Thompson** had dinner with **Miss Elsie Ha**, **Mrs. Flara Ozaki** and **Miss Alvina Chang**, who wish to send their "Aloha" to friends here.

**Kapiolani Kapers**

With a sigh of relief that the holiday season is past, we enter into 1951, hoping it will be a peaceful year for the whole world.

Looking back over 1950, we find that it went by so quickly, and there was such a great turnover that we can hardly start to name it all, but here at Kapiolani we have new faces from just about all the States, and several nurses from Canada.

**Mrs. Jeannette Summers** recently had a little daughter here, and has returned to duty as 3-11 Supervisor.

On January 18, a shower for **Miss Ruth Petersen** was given at the Nurses' Home on Punahou Street. She is from Minnesota and was married on February 3 to **Mr. Whitney Graeff**, formerly of Rhode Island and now a student at the University of Hawaii.

Back to duty after a honeymoon trip to Hawaii, is **Mrs. Nancy Coake O'Sullivan**. She was married on December 17 to **Francis O'Sullivan**, who is stationed at Schofield and serving in the Army. **Mrs. O'Sullivan** is

from Los Angeles and her husband is a resident of Honolulu.

Resigning from the Hospital, and leaving the Islands after several years here in Honolulu, is **Mrs. Jeannette McGinley**. The change is due to a transfer in her husband's position to California.

On December 17, **Miss Peggy O'Neill** resigned from the Operating Room Staff to return to Los Angeles. She has been replaced by **Miss Elizabeth Chang**, recently returned to Honolulu from Training at Presbyterian Hospital in Philadelphia.

**Mrs. Betty Radrigues** is a recent addition to the Operating Room Staff to relieve during vacations while waiting to be called into service; she is a graduate of Los Angeles County Hospital and formerly worked at Queen's Hospital.

During spare hours, if you don't find the girls at the beach, well they are either practicing the hula or the "uke" or are desperately trying to catch up on their correspondence.

And did you know, girls, that in about 20 years the male shortages will be all taken care of, because we find we have just as many boy babies as girl babies!

**Kuakini Hospital**

**Miss Ira Arashira**, graduate of Glendale Sanatorium and Hospital, Glendale, California, who attended Pacific Union College, and received her M.A. from Columbia, joined the staff January as Clinical Instructor.

**Leahi Hospital**

**Dr. Casey Domzalski** was guest speaker at the Wahine Sinclair Club. His discussion on Disaster Planning was followed by film showing of "Tale of Two Cities" and "Pattern for Survival." All hospital personnel have completed the Red Cross First Aid course in preparation for further participation in Hawaii's Defense Program.

Recent additions to the Staff are: **Carmen B. Carrean**, graduate of Philippine General Hospital, hometown, Manila, P. I.; **Kathryn Louise Fidler**, graduate of Saint Paul's School of Nursing, hometown, Cumberland, British Columbia, Canada; **Mariette Ricard**, graduate of Hotel Dieu Hospital, hometown, Grand Mere, Canada; **Marguerite Marie Briant**, graduate of Notre Dame Hospital, hometown, Saint Octave, Matane County, Quebec, Canada; **Mildred Thelma O'Brien**, graduate of Pennsylvania Hospital School of Nursing, hometown, Carlisle, Pennsylvania, and **Ruth S. Missman**, graduate of Mercy School of Nursing, hometown, Arcadia, Pennsylvania.

**Miss Anne Chang**, Supervisor of Clinical Instruction, is now **Mrs. Edward D. Camara**.

**Queen's Hospital**

New members added to the staff are **Elizabeth Burkett**, graduate of Maryview Hospital, hometown, Norfolk, Virginia; **Margaret Mishima**, graduate of Union College School of Nursing in Colorado, hometown, Honolulu; **Wanda Hesse**, graduate of Galesburg Cottage Hospital, hometown, Quincy, Illinois; **Susan Ow-yong**, graduate of St. Luke's Hospital, California, hometown, Isleton, California; **Mary Kim**, graduate of Queen's Hospital, hometown, Honolulu; **Nancy Graham**, graduate of Mount Auburn Hospital, hometown, Massachusetts; **Bodil Hansen**, graduate of Centralsygehuset, Denmark, hometown, Copenhagen, Denmark; **Harriet Owen**, graduate of Children's Hospital, California, hometown, Corning, California; **Mae Furutomo**, graduate of Queen's Hospital, hometown, Kauai; **Daris**



**Jones**, graduate of Tuomey Hospital, South Carolina, hometown, Darlington, South Carolina; **June Perrault**, graduate of University of Washington, hometown, Toppenish, Washington; **Barbara Nip**, graduate of Washington Sanitarium & Hospital, hometown, Honolulu; **Nancy Williams**, graduate of Charlotte Memorial Hospital, hometown, Halifax, Virginia; **Dorothy Arii**, graduate of Queen's, hometown, Wailuku, Maui; **Alma Buckrell**, graduate of General Hospital, Moose Jaw, Canada; **Judith Minami**, graduate of Queen's, hometown, Hana, Maui; **Tomo Hamamura**, graduate of Bronson Methodist Hospital, hometown, Portland, Oregon; **Marjorie Komeiji**, graduate of Queen's Hospital, hometown, Honolulu; **Dorothy Burtch**, O. R. Supervisor, graduate of Washington County Hospital, hometown, Ontario, Canada; **Helen Chun**, graduate of Paradise Valley Hospital in California, hometown, Honolulu; **Florence Nagao**, graduate of Massachusetts General Hospital, hometown, Honolulu; **Fumiko Sakata**, graduate of Queen's, hometown, Eleele, Kauai; **Miriam Morrison**, Obstetrics Supervisor, graduate of Western Pennsylvania, hometown, Ohio; **Kathleen Chang**, graduate of Queen's, hometown, Honaunau, Hawaii.

#### Southshore Hospital, Aiea, Oahu

**Miss Elsie Man**, R.N., a graduate of St. Francis School of Nursing, 1949, is resigning from Southshore Hospital at the end of February. She is leaving Honolulu in March to enter the University of Colorado to specialize in Nursing Education.

**Mrs. Mabel Bray**, R.N., a graduate of the Freeman Memorial Nursing School in Missouri, 1930, is a new member of the staff.

#### Tripler Hospital

Members of the Oahu Nursing Group were invited to a tea followed by a tour of Tripler Hospital on February 2.

#### News Notes:

While in the East in January, **Miss Anne Fisher** met Mrs. Thompson in Pittsburgh. Miss Fisher sends her fondest alohas to all her old friends here.

#### Kapahulu Health Center

On January 22, **Miss Fannie Chang**, clerk, **Mrs. Rose Jenkins**, cadet P.H.N., and **Mrs. Thelma Shintani** were welcomed by the "A.B.C." members. **Miss Terry Ikeda**, cadet P.H.N., has decided to shorten her course and is returning to the University for full time study.

**Mrs. Shino Murakami** left January 25 for the mainland where she and her husband will visit Mexico City, Chicago and New York. Mrs. Murakami and Miss Ikeda were bid "Aloha" on the 22nd.

**Mrs. Emilio Centeio**, P.H.N. with the Bureau of V.D. and Cancer Control, has shown the film "Very Dangerous" to Filipino speaking groups and is available for this service on application to the Bureau.

**Mrs. Kazue McLaren** has completed requirements for her baccalaureate degree in Public Health Nursing degree which she will receive at the next University Commencement.

**Miss Paula Sorg**, O.N.C. of the Department of Health was chairman of the committee on "The Exceptional Child," an institute sponsored by the Honolulu P.T.A. on Punahou Campus. Among the nurse participants were **Miss Paula Sorg**, O.N.C.; **Miss Dorothy Nagano**, P.T., and **Mrs. Marian Pang Kwock**, P.T. The institute was attended by parents, teachers, nurses, doctors, Day Care Center directors and others.

#### PRACTICAL NURSE

The Territorial Practical Nurses' Association have unanimously voted to become members of the National Federation of Licensed Practical Nurses.

The by-laws on dues have been amended, the annual dues shall be \$1.25 instead of the usual \$1.00. They have decided the \$.25 will help take care of the National dues.

At the January meeting there was a film showing the "Work of the Board of Health." After the film showing **Miss Laura Draper**, who is the Association's advisor and the Director of the Bureau of Public Health Nursing, Board of Health, spoke about the different departments of the Board of Health and their duties.

#### STUDENT NOTES:

"All work and no play makes a student nurse's life a dull life." So, there was a party, a Christmas Party, too. This is one of the bigger social activities on the Hawaii Association of Student Nurses calendar for the year.

The St. Francis Hospital nurses lounge was lit with the traditional Christmas tree, other Yuletide decorations with a background of soft Christmas music for the special occasion.

The advisors and faculty members of both Queen's and St. Francis were guests of the students. Present were **Miss Conroy**, Queen's advisor, and **Miss Bigalow**, St. Francis advisor. Mr. Whitlow, the advisor of the Student Nurses' Association, was unable to be present. Few of the faculty members present were **Miss Gibbon** of Queen's and **Miss Schuldheisz** and **Miss Tanaka** of St. Francis.

The evening started at 7:30 p.m. with games which both the students and guests enjoyed, followed by refreshments and ended at 10 p.m. with caroling by everyone.

It is a tradition for the students to hold their annual Christmas Party at Queen's one year and St. Francis another year. Last year it was held at "Hale Kula" of Queen's and this year at St. Francis Nurses' Lounge, and will continue to alternate this way.

#### WRITE FOR . . . FREE . . . AND RECEIVE

*Ethicon Cat-A-Log* and the *Ethicon Kennel Club*. In these two booklets, cat and dog pictures are cleverly combined with titles of medical personnel or with cliches commonly heard around the hospital. For example, a group of alert looking puppies sitting in an opened suit case is called "The Incoming Intern Staff." Address: Ethicon Suture Laboratories, Inc., New Brunswick, New Jersey.

*A Cancer Source Book for Nurses*. The book's 26 chapters discuss such topics as the nature of cancer, its predisposing causes, symptoms, diagnosis and treatment, psychological aspects of the care of cancer patients and the care of the terminal patient. Half of the book is devoted to describing cancer of various sites and the different problems they present to the nurse. Featured in the book are an index, bibliography and 30 illustrations and eight charts in color. Address: American Cancer Society, 47 Beaver Street, New York 4, N.Y.

#### ALPHA TAU DELTA

Are there any members of Alpha Tau Delta here in the Islands? If there are, would you please communicate with Mrs. Mabelclaire Norman at 510 S. Beretania St. Wonder just how many there are.





*"... it was discovered that Dramamine  
... is a powerful preventive of motion  
sickness."*

—Editorial: Dramamine,  
GP 2:27 (July) 1950



# DRAMAMINE<sup>®</sup> BRAND OF DIMENHYDRINATE

*—for the prevention and/or treatment of motion sickness*

For the dizziness, nausea or vomiting caused by motion, Dramamine has given unusually satisfactory results, prophylactically and therapeutically. Supplied in 50 mg. tablets and in liquid form. G. D. Searle & Co., Chicago 80, Illinois.



RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

# Pure Crystalline Vitamin B<sub>12</sub>

## PREFERRED BECAUSE

potency, purity, and lack of toxicity of *crystalline* vitamin B<sub>12</sub> are clearly established.

**Potency:** Potency of this U.S.P. product is accurately determined by precise weight.

**Purity:** Pure anti-anemia factor.

**Efficacy:** Produces, in microgram dosage, maximum hematologic and neurologic effects.

**Tolerance:** Extremely well tolerated; "no evidence of sensitivity" has been reported.

## Toxicity Studies:

- In recent pharmacologic investigations, extremely large doses of *crystalline* vitamin B<sub>12</sub> (1,600 mg./Kg.) caused no toxic reactions in any of the animals treated. In contrast, 3 mg./Kg. of a "concentrate" caused fatal reactions in 100 per cent of the animals treated.

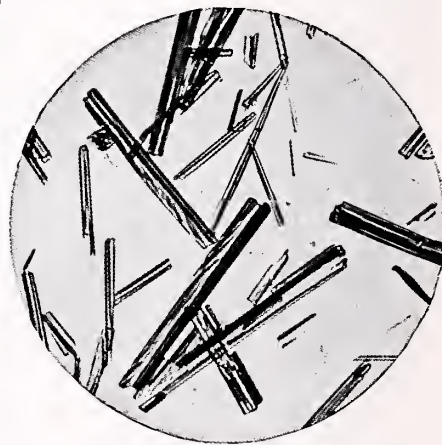
Merck—first to isolate and produce vitamin B<sub>12</sub>—supplies Crystalline Vitamin B<sub>12</sub> in saline solution under the trade-mark Cobione.\* Your pharmacist stocks Cobione in 1 cc. ampuls containing 15 micrograms of crystalline vitamin B<sub>12</sub>.

**The Only Form**

**Of This Important**

**Vitamin**

**Official In The U. S. P.**



*Crystalline Vitamin B<sub>12</sub>*

\* Cobione is the registered trade-mark of Merck & Co., Inc. for its brand of Crystalline Vitamin B<sub>12</sub>.

**B<sub>12</sub> COBIONE®**  
*Crystalline Vitamin B<sub>12</sub> Merck*



**MERCK & CO., INC.**  
*Manufacturing Chemists*  
RAHWAY, NEW JERSEY

New York, N. Y. • Philadelphia, Pa. • St. Louis, Mo. • Chicago, Ill. • Elkton, Va. • Danville, Pa. • Los Angeles, Calif.  
In Canada: MERCK & CO. Limited. Montreal • Toronto • Valleyfield

# *Intravenous* **PROCAINE**

*The least toxic of all local anesthetics*

No other local anesthetic has the extensive clinical background in intravenous use.

Therapeutically versatile...  
Clinically effective... Widely used

*Baxter PROCAINE Solutions*  
for the relief of pain

Because of its many uses,  
intravenous procaine  
has become a dependable  
therapeutic procedure  
of established value.



**BAXTER**

## **PROCAINE SOLUTIONS**

are **DILUTE** solutions...there  
is **SAFETY** in dilution

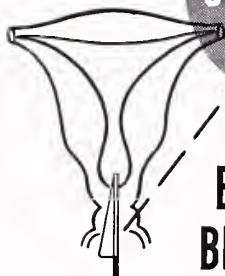
**DON BAXTER, INC.** • RESEARCH AND PRODUCTION LABORATORIES • GLENDALE 1, CALIFORNIA

*Territorial Distributors:*

**CROCKETT SALES COMPANY**

P. O. Box 3017, Honolulu, T. H., Phone 68992

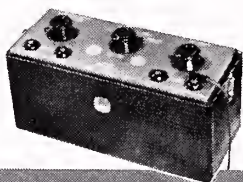


**SMOOTHER****CERVICAL  
CONIZATION***with the*  
**BIRTCHE  
BLENDTOME**

Frequent necessity of cervical repair suggests the practicality of having a BLENDTOME ELECTROSURGICAL Unit in the office or clinic. With this instrument, the doctor is enabled to do a smoother cervical conization. The BLENDTOME cuts and coagulates simultaneously with a blended current. Scar and other tissue is cut through quickly and easily; blood and lymph vessels are almost instantly sealed. The cleaner field results in reduced trauma and operative shock, smoother convalescence and more rapid healing.

The Birtcher BLENDTOME was designed for use in the doctor's office or private clinic. It provides electrosurgery for all but the strictly major cases. There are many everyday uses for the BLENDTOME—any case indicating fast and sure cutting with simultaneous sealing off of blood and lymph vessels.

Consider how much more you would be able to do with the ease, timesaving and effectiveness of a Birtcher BLENDTOME in your own office. Write for literature.

**THE BIRTCHE CORPORATION**

To: The BIRTCHE Corp., Dept. NYS, HA-3-51  
5087 Huntington Dr., Los Angeles 32, Calif.

Please send me, by return mail, free brochure  
on the portable Blendtome Electrosurgical Unit.

Dr. ....

Street .....

City..... State.....

Territorial Agent

**HOTEL IMPORT COMPANY**  
HONOLULU, T. H.

is  
your  
income  
*assured*  
?

it  
is  
if  
it's  
*insured*

Accident and health  
insurance keeps in-  
come coming in when  
it's needed most . . .

when a serious acci-  
dent or prolonged  
illness stops earn-  
ing power!

Ask about "tailored-  
to-fit" Accident and  
Health insurance with  
weekly income.

**HOME**  **INSURANCE CO.**  
**OF HAWAII, LTD.**  
HOME INSURANCE BLDG. • 129 S KING ST • HONOLULU, HAWAII, U. S. A.

KING ST., BETWEEN FORT AND BISHOP

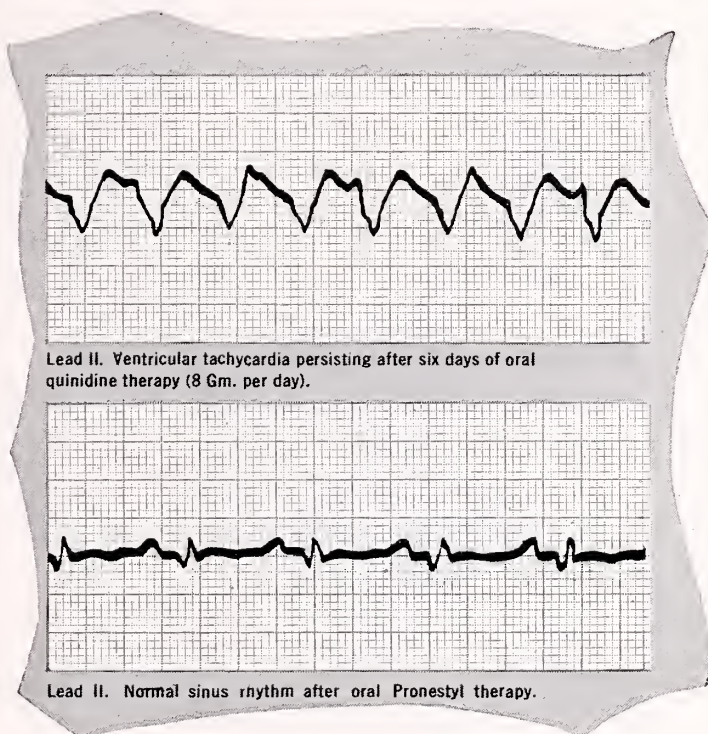
**TELEPHONE 6-3521**

a new drug . . .

*for the treatment of ventricular arrhythmias*

# PRONESTYL *Hydrochloride*

*Squibb Procaine Amide Hydrochloride*



Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evidenced by studies of blood count, urine, liver function, blood pressure, and electrocardiogram. Pronestyl may be given intravenously with relative safety.

PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.  
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

*For detailed information on dosage and administration, write for literature or ask your Squibb Professional Service Representative.*

**SQUIBB**

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

## SUCCESSFUL U

*...due to Gram-positive organisms*



Favorable response, described in many instances as "excellent," "good," and "prompt" is recorded for bacteremias caused by pneumococci, staphylococci and streptococci,<sup>1,2,3,4,5,6,7</sup> associated with pneumonia, meningitis, endocarditis, urinary tract infection, septic arthritis, and pneumonia.



CRYSTALLINE  
**Terr**

*...caused by Gram-negative pathogens*

Acute brucellosis, and Bacteroides and E. coli bacteremias have responded favorably to Terramycin therapy.<sup>7,8,9</sup> In a significant number of cases, a positive response has been noted with Terramycin after treatment with other antibiotics had been without effect.

*Antibiotic Therapy*



# ACTEREMIAS

*Terramycin may be highly effective even when other antibiotics fail.*

*Terramycin may be well tolerated even when other antibiotics are not.*

# mycin

HYDROCHLORIDE

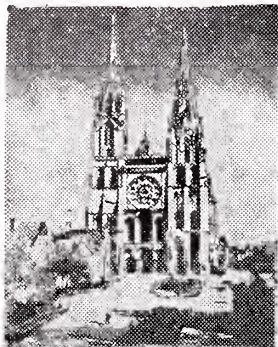


On the basis of findings obtained  
150 leading medical research centers,  
daily by mouth in divided doses q. 6  
suggested for most acute infections.

ied:  
0 mg. capsules, bottles of 16 and 100;  
0 mg. capsules, bottles of 25 and 100;  
0 mg. capsules, bottles of 25 and 100.

**Pfizer**  
CHAS. PFIZER & CO., INC.  
Brooklyn 6, N.Y.

1. Hubbard, W. N., Jr., and Tillet, W. S.: *Ann. New York Acad. Sc.* 53:429 (Sept. 15) 1950.
2. Timpanelli, A.; Huebner, R. D., and McDermott, W.: *Ann. New York Acad. Sc.* 53:440 (Sept. 15) 1950.
3. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: *J.A.M.A.* 143:1 (May 6) 1950.
4. Finland, M.; Gocke, T. M.; Jackson, G. G.; Womock, C. R., and Kass, E. H.: *Ann. N. Y. Acad. Sc.* 53:290 (Sept. 15) 1950.
5. Bauer, R. E.; Parker, R. T.; Hall, H. E.; Benson, J. F.; Joslin, B. S.; Hightower, J. A.; Snyder, M. J.; Venoble, S. J., and Woodward, T. E.: *Ann. New York Acad. Sc.* 53:395 (Sept. 15) 1950.
6. Blake, F. G.; Friou, G. J., and Wagner, R. R.: *Yale J. Biol. and Med.* 22:495 (July) 1950.
7. Herrell, W. E.; Heilman, F. R., and Wellman, W. E.: *Ann. New York Acad. Sc.* 53:245 (Sept. 15) 1950.
8. Knight, V.: *New York State J. Med.* 50:2173 (Sept. 15) 1950.
9. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: *Proc. Staff Meet. Mayo Clin.* 25:183 (Apr. 12) 1950.



Chartres Cathedral

## VISIT 11 COUNTRIES

England	Scotland
Denmark	Belgium
Norway	France
Sweden	Germany
Holland	Italy
	Switzerland

WORLD-WIDE  
IN SCOPE

# Let's go to EUROPE in 1951

**HAWAII'S OWN TOUR departs Honolulu June 13  
via S.S. Lurline**

Thrill to the Old World in company with people from Hawaii. You may choose a tour extending 58 days, 69 days, or 81 days. All accommodations guaranteed.

from **\$2079.80** plus tax

International Travel's 1951 Tour to be personally conducted by Mrs. Ruth Ross, Hawaii's only experienced European tour-conductor.



## INTERNATIONAL Travel Service

King at Bethel Streets Honolulu Ph: 59517-67558

Waikiki Branch Outrigger Arcade Between

Royal and Moano Hotels Ph: 93344-991514

Hilo Hilo Hotel Building Ph. 5328



### COSMETIC DERMATITIS?

Clinical tests confirm the use of AR-EX Cosmetics for hyper-sensitive skins. Scented or Unscented. Send for Free Formulary.

**AR-EX  
HYPO-ALLERGENIC  
COSMETICS**



### Free Diagnostic Aid

Table of cosmetic irritants and allergens—an aid in diagnosing cosmetic sensitivity—sent to physicians on request.

AR-EX COSMETICS, INC., 1036 W. VAN BUREN ST., CHICAGO 7, ILL.

# SIMPLE TEST PROVES INSTANTLY PHILIP MORRIS ARE LESS IRRITATING.

*Now you can confirm for yourself,  
Doctor, the results of the  
published studies\**

## HERE IS ALL YOU DO:

**1** . . . light up a  
**PHILIP MORRIS**

Take a puff — DON'T INHALE.  
Just s-l-o-w-l-y let the smoke come  
through your nose. AND NOW

**2** . . . light up your  
**present brand**

DON'T INHALE. Just take a puff  
and s-l-o-w-l-y let the smoke come  
through your nose. Notice that bite,  
that sting? Quite a difference from  
PHILIP MORRIS!



With proof so conclusive . . . with  
your own *personal experience* added  
to the published studies\* . . . would  
it not be good practice  
to suggest PHILIP MORRIS  
to your patients who smoke?



## PHILIP MORRIS

Philip Morris & Co., Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

\**Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592;  
*Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60





## Nembutal<sup>®</sup> ELIXIR

(PENTOBARBITAL, ABBOTT)



HERE'S a short-acting sedative in liquid form that patients old and young can take without difficulty. It's the new, improved NEMBUTAL Elixir—tops in taste, odor, color and miscibility. • The new NEMBUTAL Elixir is not a delectable treat, of course, but considering that it contains a bitter-tasting drug, it is palatable indeed. Use of SUCARYL<sup>®</sup> Sodium, Abbott's non-caloric, heat-stable sweetener, in place of much of the sugar helped to improve the taste. • The new NEMBUTAL Elixir is much less viscous than the old, making it readily miscible with other medication. It also has a wide range of compatibility, including a number of other drugs, infant's formula and whole milk, and it remains stable even when heated. • The new NEMBUTAL Elixir is available in 1-pint shelf-saving and 1-gallon bottles, each teaspoonful representing 15 mg. ( $\frac{1}{4}$  gr.) of short-acting NEMBUTAL Sodium. Other products in the NEMBUTAL line include capsules, suppositories, tablets, solutions and sterile powder for solutions. Handy small-dosage sizes simplify administration.

Abbott

**REMEMBER:** In equal oral doses, no other barbiturate combines  
QUICKER, BRIEFER, MORE PROFOUND EFFECT  
than NEMBUTAL.

WHY 8 OUT OF 10 MOTHERS WHO USE CARNATION MILK SAY:

"My doctor recommended it"

THERE ARE several hundred different brands of evaporated milk...but, for infant feeding, Carnation is the one prescribed by many of America's leading doctors and hospitals. Here are four outstanding reasons why Carnation has won the trust of the medical profession:

### 1. Carnation Research Has Improved the Raw Milk Supply

For years, champion cattle from the famous Carnation Farm have been distributed to dairy farmers all over the country, thus improving the local milk supply to the Carnation evaporating plants.

### 2. Carnation Accepts Only Quality Milk for Processing

Carnation's own Field Men regularly check the farmer's herds, sanitary conditions of the farm, and

equipment. Milk is rejected if it fails to meet any single one of Carnation's high standards.

### 3. Carnation Processes ALL the Milk Sold Under the Carnation Label

From cow to can, Carnation Milk is constantly under Carnation's own continuous control. It is processed in Carnation's own plants with "prescription accuracy" to insure uniformity of milk solid content, curd tension, viscosity and quality. Carnation never has—and never will—sell milk processed by another company.

### 4. Carnation Quality Control Continues Even AFTER the Milk Leaves the Plant

Every can of Carnation bears a control code number...so that Carnation representatives can check stocks regularly after they're shipped, to be sure mothers and hospitals will always receive fresh, high-quality milk.

No other evaporated milk goes to greater lengths to protect the doctor's recommendation. No other form of whole milk is safer or more nourishing for babies. So Carnation is the milk you can specify —by name—with complete confidence.



Don't say "Evaporated Milk"—  
say CARNATION

"The Milk Every Doctor Knows"

"from contented cows"



## *Relationship of Stress to Autonomic Lability*

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance.<sup>1,2</sup> Such states may involve any one of the organ systems or several at one time.<sup>1,3</sup> The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro- intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio- vascular System	Rapid heart rate Peripheral vaso- constriction	Slow heart rate Vasodilatation
Functional Manifesta- tions	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure  
Body Temperature Variations  
Changing pulse rate  
Deviations in B. M. R.  
Exaggerated Cold Pressure Reflex  
Oculo-Cardiac Reflex Abnormalities  
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy\*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

\*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives, 8,9,10.

1. Ebaugh, F.: Postgrad. Med. 4: 208, 1948. 2. Wilbur, D.: J.A.M.A. 141: 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. 42: 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. 27: 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. 107: 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. 58: 251, 1948.

**Sandoz**  
**Pharmaceuticals**

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, NEW YORK

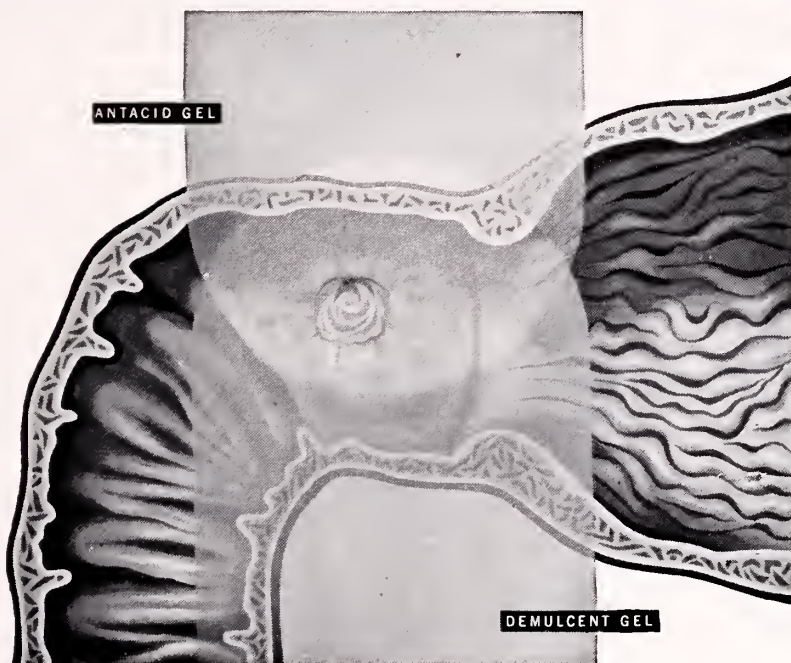
## INDEX TO ADVERTISERS

	PAGE
Abbott Laboratories .....	320
Ar-Ex Cosmetics, Inc.....	318
Ayerst, McKenna & Harrison, Ltd.....	263
Birtcher Corporation .....	314
Borden Company.....	266
Carnation Co.....	321
Dairymen's Association, Ltd.....	256
Davies, Theo. H. ....	258
Don Baxter, Inc. ....	312
Eli Lilly & Co.....	249, Insert
Hawaiian Electric Co.....	254
Home Insurance Co. ....	314
Hotel Import Co.....	264
International Travel Service.....	318
Lederle Laboratories .....	257
McArthur & Summers .....	300
Mead Johnson & Co.....	324
Merck & Company, Inc.....	317
Parke, Davis & Company.....	250, 251
Pet Milk Company .....	26
Pfizer & Co., Inc. ....	316, 317
Philip Morris & Co., Ltd., Inc.....	319
Sandoz Pharmaceuticals .....	322
Schering Corporation .....	253
Schuman Carriage Co., Ltd.....	26
Searle & Co. ....	317
Squibb & Sons .....	317
Upjohn .....	260
Wander Company.....	253
Winthrop-Stearns, Inc. ....	259
Wyeth Incorporated .....	255, 322



*Only AMPHOJEL has Double-Gel Action quickly reducing gastric acidity to non-corrosive levels . . . providing a protective, soothing coating for the ulcer crater.*

*Wyeth*  
®



## AMPHOJEL Has Many Important Advantages

for the successful medical management of acute or chronic peptic ulcer. These include:

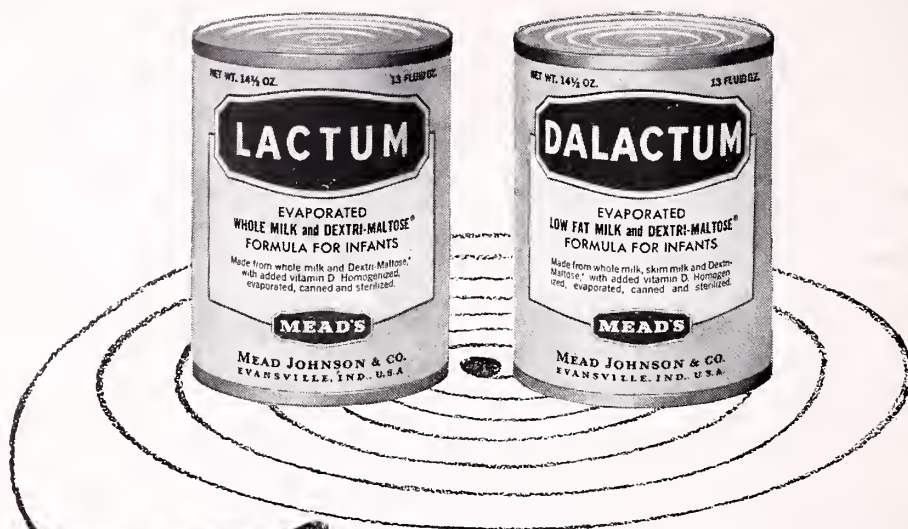
1. Relieves pain in minutes
2. Promotes healing of the ulcer crater in a matter of days
3. Does not interfere with digestion
4. No untoward effect on normal body metabolism—no acid rebound, no alkalosis
5. Does not inhibit the action of antispasmodics or laxatives if and when these are indicated
6. Safe to take for long periods of time
7. Pleasant and convenient to take
8. Economical



# AMPHOJEL®

ALUMINUM HYDROXIDE GEL • ALUMINA GEL, WYETH

WYETH INCORPORATED, PHILADELPHIA 2, PA.



# Generous

## IN PROTEIN

Since protein alone provides material for synthesis of new tissue, *generous quantities* of protein are needed in the infant's formula.

When LACTUM or DALACTUM is fed in the suggested amounts, the infant receives the National Research Council's Recommended Daily Allowance of protein with an additional margin for safety.

Although quantity of protein is important, *high quality* is essential, too.

*All* the protein of LACTUM and DALACTUM is cow's milk protein unexcelled in biologic value.

LACTUM is a whole milk and Dextri-Maltose® formula, designed for full term infants.

DALACTUM is a low fat milk and Dextri-Maltose formula, designed for prematures and full term infants with low fat tolerance.



**MEAD JOHNSON & CO.**  
EVANSVILLE 21, IND., U. S. A.

# AWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

E 10

MAY-JUNE, 1951

NUMBER 5

BY MAILING  
JUN 19 1951  
LIBRARY

REPAIR OF UNILATERAL CLEFT LIP L. Q. Pang .....	343
VITAMIN DEFICIENCIES AND DISEASE William B. Patterson.....	347
SULFONAMIDE NEPHROSIS AND ITS TREATMENT S. Mizuire.....	350
INTRA-ABDOMINAL NEUROGENIC SARCOMA Burt O. Wade.....	353
HODGKIN'S DISEASE CONTROLLED BY CHLOROMYCETIN Samuel R. Brown.....	356
FEATURES .....	359
INTER-ISLAND NURSES' BULLETIN.....	379

## REMEMBER THIS TERM?

*deaur. pil.* 

Undoubtedly you would  
if you had practiced in 1876,  
when gingerbread architecture  
and gilded pills were coming into vogue—and Eli Lilly and Company  
had just begun. Since then, the request  
to *deauratur pilulae*, meaning "let the pills be gilded,"

has become a thing of the past. The efficacy of a drug  
is a far more important consideration than the mere  
embellishment of its appearance. Now the emphasis  
in pharmaceuticals is on the certainty of response  
you can expect—when you specify Lilly.



*Lilly*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.





*allergies  
are  
always  
with us*

ALWAYS AVAILABLE

**BENADRYL<sup>®</sup>**

FOR RAPID SUSTAINED RELIEF

**PARKE, DAVIS & COMPANY**



Angioneurotic edema in January or vernal conjunctivitis in June brings patients to you seeking relief from their symptoms. BENADRYL is often the answer for many of these patients, regardless of the exciting allergen or of the shock tissue.

Hundreds of clinical reports have shown the value of BENADRYL in acute and chronic urticaria, vasomotor rhinitis, hay fever, contact dermatitis, erythema multiforme, pruritic dermatoses, dermatographism, drug sensitization, penicillin reactions, serum sickness, and food allergy.

To facilitate individualized dosage and flexibility of administration, BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a variety of forms—including Kapseals,<sup>®</sup> 50 mg. each; Capsules, 25 mg. each; Elixir, 10 mg. per teaspoonful; and Steri-Vials,<sup>®</sup> 10 mg. per cc. for parenteral therapy.

DETROIT 32, MICHIGAN



# Two Ways that Carnation Protects Your Recommendation:



# 1

Every can of evaporated milk that bears the Carnation label is processed in Carnation's *own* plants, under Carnation's *own* supervision. Carnation never has sold—and never will sell—milk processed by another company.

# 2

To meet the strict standards of the medical profession, Carnation Milk is processed with "*prescription accuracy*." Rigid control and constant testing insure complete uniformity of milk solid content, viscosity, curd tension, and *quality*—day in and year out.

**THOSE ARE THE REASONS** why you can  
specify Carnation Evaporated Milk —

*by name* — with absolute confidence that  
Carnation will justify and protect your recommendation.

We believe those two facts explain why 8 out of 10

mothers who use Carnation Milk say,

*"My doctor recommended it."*

*"From  
Contented  
Cows"*



**THE MILK EVERY DOCTOR KNOWS**



# ***predictable control of hay fever***

Chlor-Trimeton Maleate, milligram for milligram the most potent antihistamine available, allows the physician to predict a definitive and favorable result in symptomatic control of hay fever. Often successful when others fail, and producing few and minimal side effects, Chlor-Trimeton Maleate may supersede other compounds designed for the same purpose.

**Chlor-Trimeton<sup>\*</sup>**  
**maleate tablets**  
(brand of chlorphenpyridamine maleate)

Chlor-Trimeton Maleate is available in 4 mg. tablets.

<sup>\*</sup>T.M.

*Schering* CORPORATION • BLOOMFIELD, N. J.

**Chlor-Trimeton**



# Why Plasma?

## Why not whole blood?

## What about "synthetic" extenders?

---

## GOOD QUESTIONS—AND TIMELY ONES

### Plasma

Extensive experience with plasma has proved that it can serve all the purposes for which whole blood is used—except furnishing blood cells—and that it offers certain technical advantages that are of great practical importance in handling, transporting, and storing.

### Lyophilized Plasma

Lyophilized plasma, for example, can be easily carried anywhere, always ready for immediate use at *five-minute notice* without the need for typing or cross-matching. Because of these advantages, lyophilized plasma has made it possible to save the lives of thousands of desperately injured persons. It is ready for emergencies whenever blood fluids must be immediately replenished, even in extremely unfavorable field conditions in the services and under circumstances that prevail at the scene of disasters in civilian life: at automobile and train wrecks, fires in dwellings, industrial accidents, explosions, storms, and floods.

### Whole Blood

In many cases of severe bleeding the *subsequent transfusion of whole blood* is essential for ensuring the complete recovery of the patient. The use of whole blood makes possible the direct restoration of red cells thereby replacing those lost through bleeding. Nevertheless, injection of plasma is a valuable emergency measure, even in acute hemorrhage, because it has been shown that the greatest hazard is not loss of red cells but loss of fluid *volume* and the resultant fall in blood pressure that brings on circulatory failure and tissue anoxia. In such cases, infusion of plasma restores natural blood fluid,

increasing the efficiency of the circulation and so promotes delivery of oxygen to the tissues by speeding the travel of those red cells that remain. With only about two million red cells per cubic millimeter of blood, it has been found that oxygenation of the tissues may be maintained if the circulation is adequate. Naturally, the finding of such a low cell count indicates the need for giving whole blood or a suspension of red cells as soon as possible.

### Not Plasma Versus Blood

In severe burns, excessively large quantities of plasma are often lost, but red cells ordinarily do not escape from the vessels. Consequently whole blood is not usually given in the treatment of burned patients because of the possibility of thickening the blood by adding too many cells. Adequate amounts of plasma alone are urgently needed to restore circulating blood *volume*. There are also certain other uses for which plasma is better suited than whole blood, such as treatment of severe dehydration, traumatic shock, and other conditions in which circulating blood volume is reduced without excessive loss of blood cells.

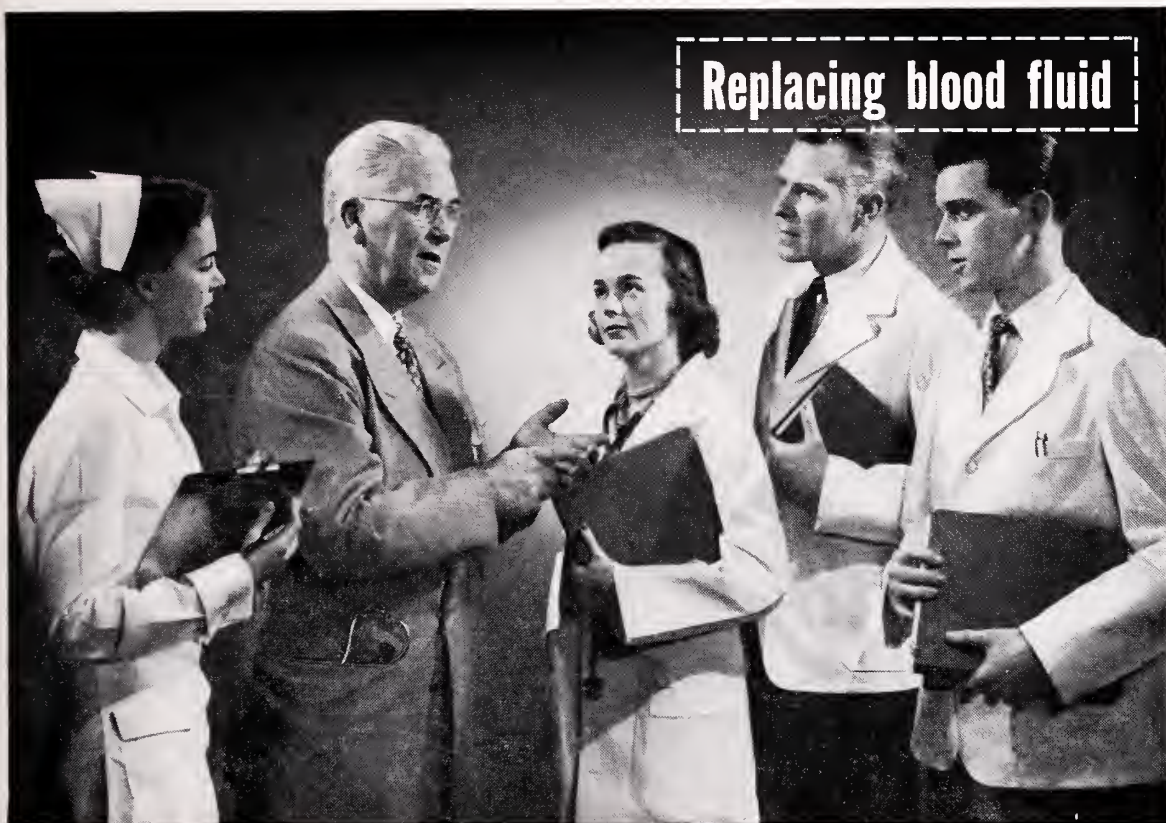
### But Plasma Plus Blood

But it should be emphasized that there are many situations in which transfusions of whole blood are indispensable. It would be unintelligent to consider *either blood or plasma* as superior to the other *in general*. Circumstances such as the patient's condition, the concentration, volume, and pressure of the blood, as well as the time element will usually determine the choice.

It is not a question of "*blood versus plasma*" but a question of how to utilize "*blood plus plasma*" to best advantage. There are no "substitutes" for either.

THEODORE H. DAVIES CO., HONOLULU





*It is not a question of "blood versus plasma" but a question of how to utilize "blood plus plasma" to best advantage. There are no "substitutes" for either.*

## Plasma "Extenders"

The possibility of a national catastrophe, in which the demand for plasma might suddenly exceed the supply, has led to the search for artificial "plasma extenders" that might be employed as temporary expedients for the emergency treatment of shock.

Recent reports about several such substances that are being used experimentally has focused attention on the mechanical aspects of maintaining the circulation. There is a natural tendency to become preoccupied with the purely *physical* considerations involved in maintaining the fluid volume of the blood and so to exclude—or to give less regard than is due to—vitally important *biological* considerations. The main objective in the search for emergency substitutes for plasma has been to find colloidal materials that could serve to imitate the natural plasma colloids in their ability to increase the osmotic pressure within the blood vessels and so to increase and maintain the amount of fluid they can retain.

## Genuine Plasma

Genuine plasma is highly efficient at performing this mechanical osmotic function—but it also does much more. Its natural colloids provide essential nutrients: *protein* for tissue regeneration; many materials necessary for maintaining vital physiologic and metabolic functions; *immune bodies* and *complement*; and substances that maintain the ability of the blood to coagulate. Plasma is the natural, biologically complete, fluid element of human blood.

## Popular Misconceptions

To physicians it is obvious that the so-called "plasma extenders" cannot be properly regarded as adequate substitutes

for plasma. To the general public, however, the distinction is not entirely clear. A recent news release from the National Research Council points out that it is important to correct popular misconceptions about "blood substitutes." Dr. Winternitz, Chairman of the Council's Division of Medical Sciences, emphasized the fact that, in his opinion, plasma extenders will be for emergency use only. Whole blood and plasma are still absolutely essential. Dr. Winternitz stated that some potential blood donors had received the impression that, since "blood substitutes" were now being made available, it would no longer be important for them to give blood. Dr. Winternitz urged that people with such mistaken notions be correctly informed. It should be made clear that blood donors are still urgently needed—for both military and civilian medicine.

Portable, and stable without refrigeration, LYOVAC® Normal Human Plasma (*Irradiated*) is prepared from fresh, citrated, human blood of carefully selected donors, according to regulations of the National Institutes of Health. The plasma is pooled, irradiated to reduce the risk of homologous serum hepatitis, rapidly frozen, *dehydrated from the frozen state under high vacuum* (the lyophile process), and sealed under vacuum.

LYOVAC Normal Human Plasma (*Irradiated*) is supplied desiccated in vacuum bottles to yield 50 cc., 250 cc., and 500 cc. of irradiated normal human plasma (containing approximately 660 mg. of *gamma globulin* in each 100 cc.), or smaller quantities of *hypertonic* plasma (with proportionately higher *gamma globulin* content).

*Sharp & Dohme, Philadelphia 1, Pa.*

**SOLE DISTRIBUTORS**





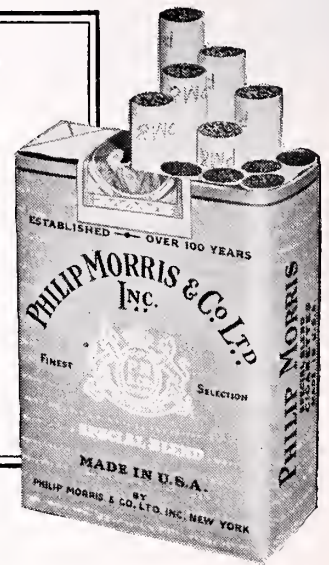
# BELIEVE IN YOURSELF!

Doctor, you probably have read a great deal of cigarette advertising with all sorts of claims.

So we suggest: make this simple test...

Take a PHILIP MORRIS—and *any* other cigarette. Then,

1. Light up either one. Take a puff — don't inhale — and s-l-o-w-l-y let the smoke come through your nose.
2. Now do exactly the same thing with the other cigarette.



*Then, Doctor, BELIEVE IN YOURSELF!*

## PHILIP MORRIS

Philip Morris & Co. Ltd., Inc.  
100 Park Avenue, New York 17, N. Y.

*occurs  
commonly*

*potentially lethal*

# Potassium Deficiency

*easy to overlook*

## KALADEX

(Baxter 0.2% Potassium Chloride in 5% Dextrose Solution)

*provides a*  
**SAFE, FAST, EFFECTIVE THERAPY**

### RECOGNIZE THE SYNDROME



Low plasma potassium...EKG changes...profound muscle weakness...respiratory distress

### TREAT PROMPTLY

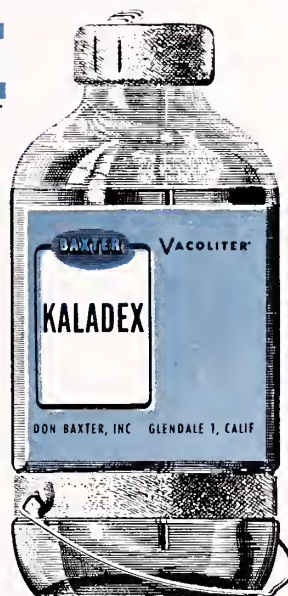


With KALADEX

### SAFETY



KALADEX is a *dilute* solution.  
There is *safety* in dilution.



*Eliminate the danger of potassium deficiency. When parenteral potassium is indicated...use*

**KALADEX**



DON BAXTER, INC. • RESEARCH AND PRODUCTION LABORATORIES • GLENDALE 1, CALIFORNIA

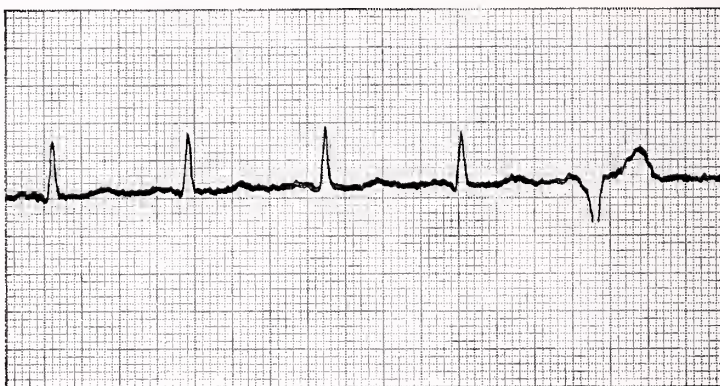
*Territorial Distributor*

**CROCKETT SALES COMPANY**

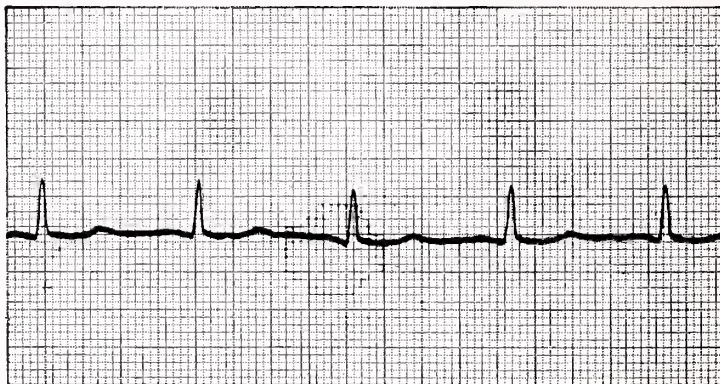
P. O. Box 3017, Honolulu, Hawaii • Phone 6-8992

*a significant advance in the  
treatment of ventricular arrhythmias . . . .*

Oral PRONESTYL  
in ventricular premature contractions



Lead I. Control tracing, ventricular premature contraction.



Lead I. Tracing one week later; patient maintained on 2 Gm. Pronestyl per day. Normal sinus rhythm.



# ....PRONESTYL *Hydrochloride*

*less toxic than quinidine*

## Indications and Dosage

### IN CONSCIOUS PATIENTS

*For the treatment of ventricular tachycardia:*

*Orally:* 1 Gm. (4 capsules) followed by 0.5-1.0 Gm. (2 to 4 capsules) every four to six hours as indicated.

*Intravenously:* 200-1000 mg. (2 to 10 cc.). *Caution*—administer no more than 200 mg. (2 cc.) per minute.

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. *If marked hypotension occurs, rate of injection should be slowed or stopped.*

*For the treatment of runs of ventricular extrasystoles:*

*Orally:* 0.5 Gm. (2 capsules) every four to six hours as indicated.

### IN ANESTHESIA

*During anesthesia, to correct ventricular arrhythmias:*

*Intravenously:* 100-500 mg. (1 to 5 cc.). *Caution*—administer no more than 200 mg. (2 cc.) per minute.

## Supply

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.  
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

# PRONESTYL *Hydrochloride*

SQUIBB PROCAINE AMIDE HYDROCHLORIDE

## SQUIBB

# SOPRONOL IN DERMATOPHYTOSIS

(Athlete's Foot)



## Effectiveness and Safety Proved in Clinical Practice

Two recent reports on SOPRONOL therapy establish its value.

1. "Propionate-caprylate mixtures...proved superior to other local medications used in 10 patients observed during this study ... No instances of irritation or sensitivity were observed."<sup>1</sup>  
2. "In this series of 39 patients ... the conclusion is reached

that propionate-caprylate treatment is eminently effective ... None of the patients complained of irritation and there was no evidence of sensitization. On the contrary, pre-existing 'id' areas disappeared during treatment."<sup>2</sup>

1. Nettleship, A.: Arch. Dermat. & Syph. 61:669, 1950  
2. Brewer, W. C.: Arch. Dermat. & Syph. 61:681, 1950

Sopronol therapy is a therapy of choice with physician after physician.



# SOPRONOL®

PROPIONATE-CAPRYLATE COMPOUNDS Wyeth

### ointment

Sodium propionate	12.3%
Propionic acid	2.7%
Sodium caprylate	10.0%
Zinc caprylate	5.0%
Diethyl sodium sulfosuccinate	0.1%
Inert ingredients	69.9%
including n-Propyl Alcohol	10.0%
1 oz. tubes	

### POWDER

Calcium propionate	15.0%
Zinc propionate	5.0%
Zinc caprylate	5.0%
Inert ingredients	75.0%
2 and 5 oz. canisters	

### SOLUTION

Sodium propionate	12.3%
Propionic acid	2.7%
Sodium caprylate	10.0%
Diethyl sodium sulfosuccinate	0.1%
Inert ingredients	74.9%
including n-Propyl Alcohol	12.5%
2 oz. bottles	

Wyeth Incorporated, Philadelphia 2, Pa.

IN  
THE  
AIM  
TOWARD



# Lessening Illness in the Aged

By maintaining complete adequacy of the diet during advancing years, considerable can be accomplished in reducing the frequency of illness in the aged population and in favorably influencing the mental state of the geriatric patient. In particular, ample intake of protein, vitamins, and minerals is needed for preventing many somatic and psychic symptoms of malnutrition often observed in the aged.<sup>1</sup>

The dietary supplement, Ovaltine in milk, is a reliable aid for supporting the nutritional state of the elderly patient.

This nutritious beverage richly provides biologically complete protein, minerals—especially calcium and iron—and all the vitamins considered essential. Used in the recommended amount, it can readily supplement even poor diets to full nutrient adequacy. It is easily digestible, invigorating, and pleasingly palatable.

Note the wealth of nutrients furnished by Ovaltine in milk, as shown by the table given below.

1. Thewlis, M., and Gale, E. T.: Ambulatory Care of the Aged, *Geriatrics*, 5:331 (Nov.-Dec.) 1950.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

## Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,\* provide:

PROTEIN . . . . .	32 Gm.	VITAMIN A . . . . .	3000 I.U.
FAT . . . . .	32 Gm.	VITAMIN B <sub>1</sub> . . . . .	1.16 mg.
CARBOHYDRATE . . . . .	65 Gm.	RIBOFLAVIN . . . . .	2.0 mg.
CALCIUM . . . . .	1.12 Gm.	NIACIN . . . . .	6.8 mg.
PHOSPHORUS . . . . .	0.94 Gm.	VITAMIN C . . . . .	30.0 mg.
IRON . . . . .	12 mg.	VITAMIN D . . . . .	417 I.U.
COPPER . . . . .	0.5 mg.	CALORIES . . . . .	676

\*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving far serving, they are virtually identical in nutritional content.

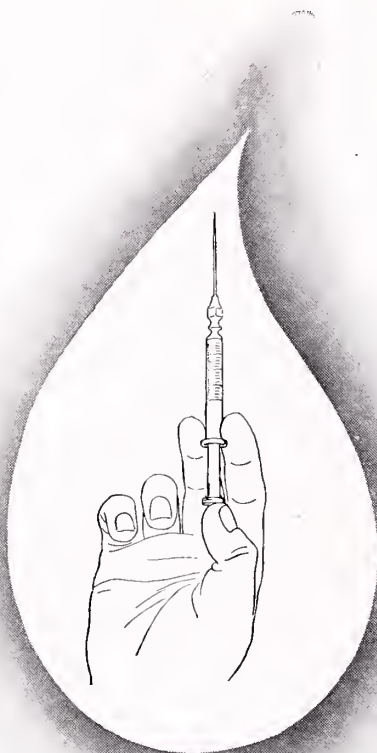




# Dihydrostreptomycin Sulfate

## a Drug of Choice

## for Physician and Patient



Extremely well tolerated and rarely causing irritation on injection, Dihydrostreptomycin Sulfate has become a most widely accepted streptomycin preparation.

**Comparative studies by leading clinicians confirm that DIHYDROSTREPTOMYCIN SULFATE IS —**

*as effective as streptomycin 2, 9, 13-15  
less toxic for the vestibular apparatus 1-15  
minimizes pain and swelling at the site of injection 6:10  
may be used even in patients showing allergic response to streptomycin 2, 9, 10, 11*

**Extensive experimental studies 6, 9, 16-18**

**proved CRYSTALLINE DIHYDROSTREPTOMYCIN SULFATE MERCK**

**less toxic for the vestibular system.**

### BIBLIOGRAPHY

(1) Tompsett, R., and McDermott, W., *Am. J. Med.* 7: 371-381, Sept. 1949. (2) Tompsett, R., *Ann. Otol., Rhin. & Laryng.* 57: 181, March 1948. (3) Sweany, H. C., *Dis. Chest* 15: 631-656, June 1949. (4) Lincoln, S., *Science News Letter* 55: 307, May 14, 1949. (5) Semans, J. H., *J. M. A. Georgia* 38: 477-480, Nov. 1949. (6) Domon, C. M., Kilbourne, P. C., and King, E. Q., *Amer. Rev. Tuberc.* 60: 564, 575, Nov. 1949. (7) Nagley, M. M., *Brit. M. J.* 1: 248, Jan. 28, 1950 (in correspondence). (8) Committee on Medical Research and Therapy, American Trudeau Society, *Am. Rev. Tuberc.* 61: 436-440, March 1950. (9) Carr, D. T., Hinsbaw, H. C., Pfuetze, K. H., and

Brown, H. A., *Dis. Chest* 16: 801-821, Dec. 1949. (10) Odell, J. M., *Dis. Chest* 16: 818, Dec. 1949. (11) (Editorial) *New England J. Med.* 240: 736, May 5, 1949. (12) Keefer, C. S., *Ann. Int. Med.* 33: 582-589, Sept. 1950. (13) Marsh, D. F., *W. Va. Med. J.* 45: 280-284, Oct. 1949. (14) Johnson, H. M., *J. Invest. Dermat.* 15: 61-66, July 1950. (15) Hinshaw, H. C., Personal communication. (16) Lincoln, N. S., Horton, R., Stokes, A. M., Monroe, J., and Riggins, H. M., *Am. Rev. Tuberc.* 62: 572-581, Dec. 1950. (17) Carr, D. T., Brown, H. A., Hogson, C. H., and Heilman, F. R., *J. A. M. A.* 143: 1223-1225, Aug. 5, 1950. (18) Jacoby, A., Goldberg, W., Sobel, N., and Rosenthal, T., *Am. J. Syph., Gonorr. & Ven. Dis.* 34: 185-186, March 1950.

*Supplied By Merck In The Purest Form Available —*

## CRYSTALLINE DIHYDROSTREPTOMYCIN SULFATE MERCK

Crystalline Dihydrostreptomycin Sulfate Merck is supplied in convenient 1 Gm. and 5 Gm. vials.



**MERCK & CO., INC.**

*Manufacturing Chemists*

RAHWAY, NEW JERSEY

## As if there were no germ of disease

Illness interferes with best growth. You want infants in your care to have every possible protection against disease in order to help maintain sure steady growth and development.

That's why so many physicians everywhere recommend Pet Evaporated Milk for infant formula. Sterilized in its sealed container, permanently protected from any source of contamination, Pet Milk is completely safe, as if there were no germ of disease in the world.

You are assured, too, that safe Pet Milk retains all the food values the best milk can be depended upon to supply... and that these food values are uniform wherever and whenever this good milk is purchased.

And it's thrifty! Pet Milk, the original evaporated milk, costs less than any other form of milk... far less than special infant feeding preparations!

Try Pet Milk for the babies in your care! Let this safe, low-cost milk help you in your continuous fight against disease!

**Favored Form  
of Milk for  
Infant Formula**



**PET MILK COMPANY, 1424-E Arcade Building, St. Louis 1, Missouri**

## *Did You Hear The One About . . . .*

The girl who would do anything  
to get a mink coat? ? ?

*Or*

I *used* to be a Democrat  
As happy as could be,  
But *now* I wish I were a dog,  
And .....

*Seriously*

As "Pharmacists"  
We TRY to have ALL  
the Answers.

*A Call to*

6-6044 or 6-8865  
*and we'll do our best  
to prove it.*



McARTHUR & SUMMERS  
PRESCRIPTION • PHARMACISTS

PHONES 6-6044  
6-8865

THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONES  
7-5419 • 7-8411



# HAWAII MEDICAL JOURNAL

and

## INTER-ISLAND NURSES' BULLETIN

Volume 10  
Number 5

MAY-JUNE, 1951

\$2.00 per year  
35c per copy

---

Published Bi-Monthly by  
THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

---

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

---

### THE HAWAII TERRITORIAL MEDICAL ASSOCIATION

1951-1952

#### OFFICERS

HARRY L. ARNOLD, JR., Honolulu.....	President
R. J. McARTHUR, Wailuku, Maui.....	President-Elect
T. DAVID WOO, Pepeekeo.....	Vice-President from Hawaii County
JOHN W. DEVEREUX, Honolulu.....	Vice-President from Honolulu County
K. K. FUJII, Kapaa.....	Vice-President from Kauai County
E. T. SHIMOKAWA, Lahaina.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

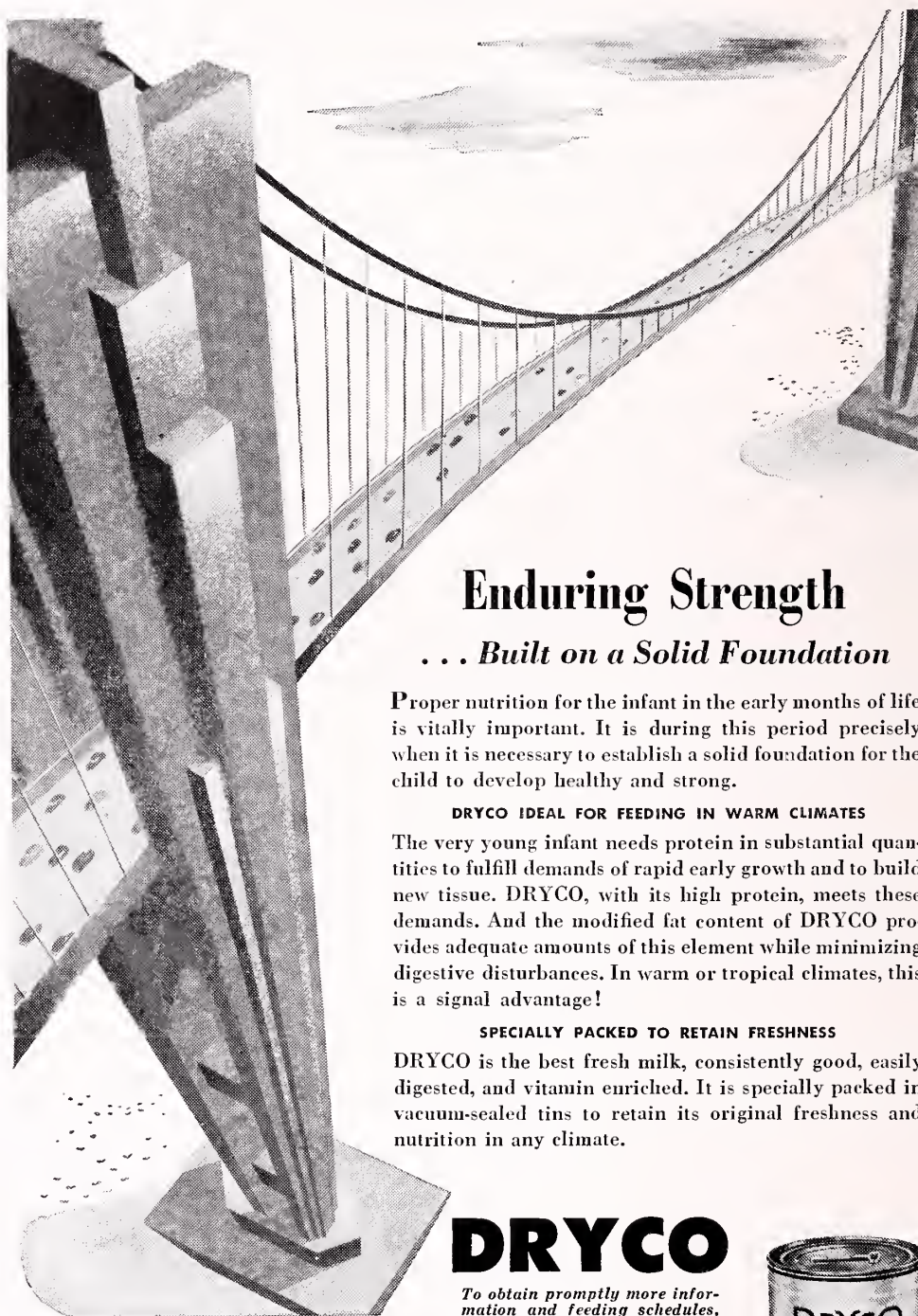
#### OFFICERS — COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....T. David Woo, Pepeekeo	John W. Devereux	K. K. Fujii, Kapaa	Edw. T. Shimokawa, Lahaina
<i>Vice-President</i> .....S. Kasamoto, Hilo	Wm. M. Walsh	Keith Kuhlman, Koloa	John A. Burden, Paia
<i>Secretary</i> .....Francis Wong, Hilo	Wm. S. Ito	C. H. Ishii, Lihue	Edward Kushi, Wailuku
<i>Treasurer</i> .....Richard Hata, Hilo	C. M. Burgess	C. H. Ishii, Lihue	Edward Kushi, Wailuku

---

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1951, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.



## Enduring Strength

*... Built on a Solid Foundation*

Proper nutrition for the infant in the early months of life is vitally important. It is during this period precisely when it is necessary to establish a solid foundation for the child to develop healthy and strong.

### DRYCO IDEAL FOR FEEDING IN WARM CLIMATES

The very young infant needs protein in substantial quantities to fulfill demands of rapid early growth and to build new tissue. DRYCO, with its high protein, meets these demands. And the modified fat content of DRYCO provides adequate amounts of this element while minimizing digestive disturbances. In warm or tropical climates, this is a signal advantage!

### SPECIALLY PACKED TO RETAIN FRESHNESS

DRYCO is the best fresh milk, consistently good, easily digested, and vitamin enriched. It is specially packed in vacuum-sealed tins to retain its original freshness and nutrition in any climate.

# DRYCO

*To obtain promptly more information and feeding schedules, address a card or letter to:*

**THE BORDEN COMPANY**  
(Export Division)

350 Madison Avenue  
New York 17, N. Y., U. S. A.





# The Repair of Unilateral Cleft Lip

L. Q. PANG, M.D.  
HONOLULU



DR. PANG

APPROXIMATELY a thousand children are born each year in the United States with a cleft lip, with or without an associated cleft palate. In Hawaii, one of every 950 births results in this deformity. The care and rehabilitation of these unfortunates constitutes a problem of major proportions. In no case of plastic surgery is the operation more difficult and in none does so much depend upon a good result as to both appearance and physiologic action. In most of these children, there is sufficient tissue to effect an acceptable surgical repair. However, it is not always possible to obtain so good a cosmetic result that the lips and nostril lose the "cleft lip" appearance. A great deal depends upon the original deformity, the width of the lip cleft, the associated nasal deformity and the accompanying alveolar and palate cleft.

In a complete cleft of the lip with or without an alveolar or palate cleft, the following defects are noted: (Fig. 2, A&B). (1) The nasal columella is deviated towards the good or intact side. (2) There is a marked flattening in varying degrees of the nostril of the cleft side. (3) The long axis of the nostril on the cleft side is more transverse than that of its fellow; the nostril as a whole is somewhat posterior to its fellow and the nose is correspondingly flattened on that side.

To correct these deformities, it is necessary first to mobilize all the mal-related structures; second, to bring them into the most natural form and position obtainable; and third, to fix them by sutures until healing has occurred with the least amount of external scar.

The question has always been asked, "When should a cleft lip be operated on?" This question is natural in view of the anxiety of the parents and the embarrassment caused by the deformity. There is no unanimity of opinion as to the answer.

Blair,<sup>1</sup> Brown Byars and McDowell<sup>2</sup> prefer to operate as soon as possible after birth. They feel that during the first few days of life, there probably remains some of the immunity to surgical shock which is necessarily present during the process of birth. Vaughn<sup>3</sup> and others wait until the infant regains its birthweight and shows a steady gain. This also allows the pediatrician to find a more suitable formula before surgery. In our hands, we have found this last method more practical.

Brown & McDowell<sup>2</sup> list the following important points to be obtained in order to get good cosmetic result: (1) A symmetrical alar level. (2) A good alar direction towards the columella. (3) A satisfactory nostril floor. (4) A normal nostril curve. (5) A full lip border in advance of the lower lip with a normal concavity from above down. (6) A straight columella. (7) A full vermillion without a "whistling deformity."

In my opinion, the repair of the nose is the most important part of the surgery. The immediate proper adjustment of the lip itself is of secondary importance to the nostril. A normal looking nose will do more than anything else to eradicate the "cleft lip" appearance (Fig. 2 C). A poor adjustment of the nostril will be followed by an increasing deformity of the bones and cartilages of the nose. No matter how poor the adjustment of the lip, it will pull the separated halves of the alveolar cleft into good relationship. Furthermore, readjustments of the lip can be done more easily by a secondary repair.

In the repair of the lip, the question of what to do with an open alveolar cleft was a big one. Many of the older surgeons, notably Brophy and his followers, repaired the lip and palate after a preliminary forceful closure of the alveolar cleft. The separate halves of the alveolar border and palate were forcibly approximated by digital pressure and then maintained in that position by the use of wires twisted down on lead plates against the alveolus. While the immediate results were good, bad deformities of the upper jaw gradually

<sup>1</sup> Blair, V. P., and Brown, J. B.: Mirault Operation for Single Harelip, *Surg. Gynec. & Obst.* 51:81, 1930.

<sup>2</sup> Brown, J. B. & McDowell, F.: Simplified Design for Repair of Single Cleft Lips, *Surg. Gynec. & Obst.* 80:12 (Jan.) 1945.

<sup>3</sup> Vaughn, H. S.: Congenital Cleft Lip, Cleft Palate and Associated Nasal Deformities, Phila., Lea & Febiger, 1940.





Fig. 1 A.—A unilateral incomplete cleft lip.

Fig. 1 B.—Repair using the Thompson method.

developed so that these patients all developed a physiognomy that is typical and characteristic of this condition. The middle of the face is depressed as a result of the extreme retraction of the maxilla resulting from an interference with its growth. Consequently there is protrusion of the mandible with a resulting pseudo-prognathism. Furthermore, there is a premature loss of the first, and subsequent derangement of the tooth buds of the permanent, teeth. These deformities may be corrected to some extent by years of orthodontic work or by extensive prosthetic procedures.

It remained for Blair and his associates to emphasize this untoward result. Most of the surgeons now do not forcibly approximate the alveolar cleft but depend upon the closure of the lip to approximate the two separate halves. After the closure of the lip, one can actually watch the two halves of the alveolar cleft gradually grow closer and finally approximate. Vaughn states that he has seen cases of lip repair that still have separated alveolar borders with an opening into the nasal floor under the lip. He approximates the two halves of the alveolus by digital

pressure and then maintains it in position by means of silver wires put through the maxilla well above the tooth-bearing area, to avoid injury to the follicles of the permanent teeth. In our series of cases, no forcible digital manipulation was done, and in all the alveolar borders approximate well.

Our technic varies with the incomplete and the complete cleft. In the repair of the incomplete cleft, we prefer Thompson's method of repair. It is simple and gives us the desired result (Fig. 1).

In the repair of the complete cleft lip, we prefer the method of Brown & McDowell. This simplified design allows more time for concentration

on the fundamentals involved in shifting the tissues and in their fixation. It makes use of a small triangular flap in the cleft side of the upper lip which helps in thrusting the lower border of the lip forward in advance of the lower lip. Formerly we used the Blair-Mirault operation but have found the Brown-McDowell operation much simpler. Recently LeMesurier<sup>4</sup> and Steffenson<sup>5</sup> have described their methods of cutting and sutur-

<sup>4</sup> LeMesurier, A. B.: A Method of Cutting and Suturing the Lip in the Treatment of Complete Unilateral Clefts, *Plastic & Reconst. Surg.* 4:1 (Jan.) 1949.

<sup>5</sup> Steffenson, W. H.: A Method of Repair of the Unilateral Cleft Lip, *Plastic & Reconst. Surg.* 4:144 (March) 1949.



Fig. 2 A & B.—A complete unilateral cleft with an associated palate cleft. Note the following:—(1) Lateral deviation of nose so that the columella is deviated towards the intact side; (2) marked flattening of nostril of cleft side; (3) long axis of nostril of cleft side more transverse than and somewhat posterior to that of its fellow.

Fig. 2 C.—Same case after the repair. The cleft lip appearance is gone because of a good nostril repair. There is a symmetrical alar level; a good alar direction towards the columella; a normal nostril curve and a straight columella.

ing the lip which are modifications of the Hagedorn method. All these methods stress the best attainable nasal adjustment and a lip scar that is not in a straight line in order to create a full upper lip and to obviate the whistling deformity caused by the contraction of a straight line scar.

The operative procedure consists of: (1) Marking out the flaps. (2) Mobilizing the lip and nose. (3) Excising the cleft. (4) Closure of the lip.

The marking of the lip is done with a mechanical drawing pen and 5 per cent alcoholic methylene blue. The points are measured off with a fine pointed divider and then the line between points is lightly incised with a knife. The lip and nose are then mobilized on both sides, the mobilization being more extensive on the side of the cleft. At this point, the nose can be mobilized by introducing a pair of small scissors through the buccal fornix and elevating the skin of the nose throughout the lower half and over and across the midline of the normal nose. This single procedure is of the utmost importance as it aids in rounding out the nostril and giving it a normal nostril curve and a good alar direction.

The lines between the points are now cut through the full thickness of the lip. The lip is then closed using 000 catgut sutures for the mucosal surface and 5-0 atraumatic nylon sutures for the skin surface. Forceps should never be used on the skin as they leave tell-tale marks on the skin. Brown advised using the gloved fingers for holding the lip while Slaughter<sup>6</sup> advised the use of skin hooks. Brown lays great stress on the closure of the mucosal surface as it closes the entire lip for primary healing, prevents adhesion of the lip to the raw pre-maxilla and thrusts the upper lip forward. Great care should be exercised in closing the floor of the nose. The nostril can be somewhat shaped by a few mattress sutures through it from the skin

surface to pick up the mucosa, these two surfaces having been separated during dissection. In case there still is a flattening and widening of the nostril, the procedure recommended by Steffenson, where he frees the lower lateral cartilage by an incision just inside the rim of the nostril connected with the previous undermining, works well. A few stay sutures of B black silk may be put in from the mucosal surface if desired, going through the lip almost to the skin. Deep stay sutures on the skin have no place in lip surgery as they leave wide marks that are disfiguring and are almost impossible to remove. At the end of the



Fig. 3 A & B.—Complete unilateral cleft lip associated with a cleft palate.

Fig. 3 C.—Lateral view following repair. Showing full lip border in advance of the lower lip with a normal concavity from above down. This gives the appearance of a typical "baby lip." This result is obtained by careful closure of the mucosal surface of the lip and by use of the triangular flap recommended by Brown & McDowell.

Fig. 3 D.—Front view showing a full vermilion border and the satisfactory nose repair.

<sup>6</sup> Slaughter, W. B., and Brodie, A. G.: *Facial Clefts and Their Surgical Management in View of Recent Research, Plastic & Recons. Surgery*. 4:311 (July) 1949.



operation, the nostril is packed with vaseline gauze and the wound is covered with furacin ointment dressing. A Logan bow is then applied.

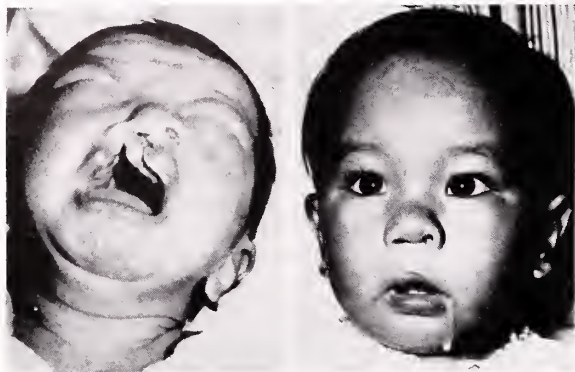


Fig. 4 A.—Unilateral complete cleft lip associated with a wide alveolar and palate cleft.

Fig. 4 B.—Fair nose repair and a slight irregularity of the vermillion border. Note that in spite of the errors, the cosmetic result is fair because of the rounded nostril curve and a fairly straight columella.

Regardless of at what age an infant is operated on, he should have a thorough physical examination and be brought up to the best of physical condition. In the work with the Bureau of Crippled Children, the infants are admitted well before surgery and are checked by a pediatrician. Active skin infections, respiratory infections, prolonged bleeding and coagulation time are contraindications to surgery. A complete blood count is done and if the hemoglobin or red cell count is low, a preliminary blood transfusion is given. Feeding is always a problem especially if the palate is open. In our series, the infants are fed with a medicine dropper or a syringe. Gavage is not done as the esophagus of the infant cannot stand this procedure long. Feeding is allowed up to four to six hours before surgery and water up to two hours before surgery. Atropine sulphate is not given to these infants.

The anesthesia used is ether which is given by means of a blower. This is supplemented by 1 per cent novocaine and adrenalin which also aids in hemostasis.

Post-operatively, the patient is put on his abdomen to allow blood to run out of the mouth. The silk stitch which is put through the tongue at the beginning of the operation is left in and serves as a good method for maintaining the airway until the patient is awake. The patient's hands

are kept away from the lips by means of a special tongue blade cuff around the elbows. The gauze dressing on the lip is changed daily or oftener if necessary. For the first twenty-four hours the infant is given a 10 per cent glucose solution in lieu of the milk formula. After this period, the milk formula is resumed. The feeding is done by means of a syringe with a rubber tip, a medicine dropper or a spoon. Sedation with sodium luminal is given as is necessary. The vaseline gauze packings are removed from the nostrils after forty-eight hours. The skin sutures are removed after four days and the deep sutures after ten days.

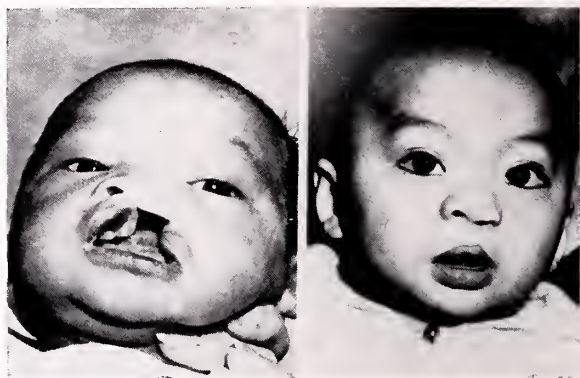


Fig. 5 A.—A complete unilateral cleft lip with an extremely wide alveolar and palate cleft and an extreme flattening of the ala on the cleft side so that it is almost horizontal.

Fig. 5 B.—Post-operative result. This case illustrates several points:—(1) It is not always possible to get good cosmetic results. A great deal depends upon the width of the cleft lip, the associated nasal deformity and the accompanying alveolar and palate cleft. (2) Note the extreme wide alveolar cleft. Although the lip repair was not perfect and there was no forceful manipulation of the alveolus, the two anterior portions of the alveolus became approximated after one month. In this case we actually watched the two portions of the alveolus gradually approximate each other.

### Summary

1. One out of every 950 births in Hawaii results in a cleft lip with or without an associated cleft palate.
2. There is no unanimity of opinion as to when a child with a cleft lip should be operated on. We prefer to operate on the infants after they have regained their normal birth weights and are gaining in weight.
3. A brief description of the operative procedure, and the pre- and post-operative care is given.



# Vitamin Deficiencies and Disease

WILLIAM B. PATTERSON, M.D.

PUUNENE, MAUI

**D**ISEASE is present when any of the functions of the body are abnormal. Every physiologic function is the result of many intracellular biochemical reactions and each biochemical reaction is dependent upon a specific enzyme system. These enzyme systems function in an organized manner depending upon the molecular and structural arrangement of the protoplasm within the particular cell<sup>1</sup>.



DR. PATTERSON

Vitamins have been found to form parts of the intracellular enzyme systems<sup>2</sup>, and various hormones have been found to be necessary for the enzyme systems to function<sup>1</sup>. The hormones are not utilized in the biochemical reactions as the vitamins are, but they actively control cellular metabolism.

Normal cellular metabolism is dependent upon an adequate supply of specific hormones, vitamins and enzymes, in addition to carbohydrates, fats, proteins and minerals. Any vitamin deficiency which impairs normal cellular metabolism, appears to stimulate the glands which furnish the hormones that are used in the vitamin-deficient cells. Excess production of hormones due to a vitamin deficiency may produce hypertrophy and hyperplasia of certain endocrine glands.

A vitamin deficiency, single<sup>3</sup> or multiple<sup>4</sup>, produces hyperplasia and hypertrophy of the adrenal cortex. If the vitamin deficiency is marked, the hyperplasia of the adrenal cortex may cause the adrenal gland to more than double its size. Deficiencies of vitamin A, thiamin, riboflavin, ascorbic

acid, vitamin D, tocopherols, pantothenic acid and niacin, together and singly, have been demonstrated to produce hypertrophy of the adrenal cortex, whereas a deficiency of carbohydrate, protein or fat, when all the other food factors are present, leads to atrophy of the adrenal cortex. This hypertrophy of the adrenal cortex in vitamin deficiencies I interpret as showing that the adrenal cortex hormones are needed to activate intracellular enzyme systems.

Histologically the adrenal cortex is divided into three indistinct layers of polyhedral cells<sup>5</sup>. The cells of the outer layer are arranged in rounded groups, are granular and stain deeply. The cells of the second layer are arranged in radial columns. They contain fine granules and globules of lipoid material. The cells of the inner layer form cylindrical masses and contain dark staining pigment granules. The cells all have the same blood supply, which comes from the capsule.

Twenty-eight steroid compounds, and many nonsteroid compounds, have been isolated from the adrenal cortex<sup>6</sup>. The amorphous fraction of the cortex remaining after the steroids have been removed, is very active biologically and will maintain life in adrenalectomized animals. The amorphous fraction contains the greater part (estimated as much as 90 per cent<sup>7</sup>) of the biological activity of the adrenal cortex<sup>6</sup>.

The exact functions of all the compounds isolated from the adrenal cortex have not been determined, but the functions of some are known. For instance, it is known that corticosterone controls carbohydrate metabolism, and that desoxycorticosterone regulates the electrolyte composition of the body fluids<sup>8</sup>. Protein and fat metabolism are controlled by the adrenal cortex. Hormones with androgenic, estrogenic and lactogenic<sup>6</sup> properties, as well as progestins, have been obtained from the adrenal cortex<sup>9</sup>. Some adrenal

Read before the Seventh Annual Meeting of the Territorial Association of Plantation Physicians at Lihue, Kauai on November 10, 1950. Received for publication January 9, 1951.

<sup>1</sup> Soskins, S.: *Progress in Clinical Endocrinology*, New York, Grune & Stratton, 1950, pages 1-8.

<sup>2</sup> Kleiner, I. S.: *Human Biochemistry*, 2nd edition, St. Louis, C. V. Mosby Co., 1948, pages 301-317.

<sup>3</sup> Williams, R. R., and Spies, T. D.: *Vitamin B<sub>1</sub>*, New York, the Macmillan Co., 1939, page 60.

<sup>4</sup> Hartman, F. A., and Brownell, K. A.: *The Adrenal Gland*, Phila., Lea & Febiger, 1949, page 28.

<sup>5</sup> Soffer, L. J.: *Disease of the Adrenal Gland*, Phila., Lea & Febiger, 1948, page 17.

<sup>6</sup> Reichstein, T., and Shoppe, C. W.: *Vitamins and Hormones*, Vol. I, New York, Academic Press, 1943, page 345.

<sup>7</sup> Hartman, F. A., and Brownell, K. A.,<sup>4</sup> page 106.

<sup>8</sup> Harrison, H. E.: *Progress in Clinical Endocrinology*, New York, Grune & Stratton, 1950, page 137.

<sup>9</sup> Wilhelm, S. F.: *Progress in Clinical Endocrinology*, New York, Grune & Stratton, 1950, page 151.

cortex hormones have actions similar to the cardiac glucosides (digitalis)<sup>10</sup>. Liver function is somehow controlled by the adrenal glands, as shown by the fact that in chloroform poisoning the life cycle of the cells of the adrenal cortex is shortened<sup>11</sup>, and in adrenalectomized animals, the liver is not injured by chloroform.

The diverse clinical syndromes seen in adrenal gland disease illustrate the fact that the adrenal gland produces hormones that affect almost every part and function of the body. Tumors of the adrenal gland may affect only one function of the body, or produce syndromes such as the adrenogenital syndrome or Cushing's syndrome which involve many functions.

The importance of the adrenals in body physiology is shown in Addison's disease, where there is usually only a partial destruction of the adrenal glands. If adrenal destruction is rapid and complete, death occurs.

The administration of ACTH causes an increase in function of the adrenal cortex, thereby producing changes in almost every part of the body. Changes have been observed in the function of the thymus, thyroid, lymph glands, islets of Langerhans, skin, blood, forming tissues, kidneys, brain, temperature regulation mechanism, joints, muscles, intestines, heart, nerves and other parts<sup>12</sup>.

The extreme hyperplasia and hypertrophy of the adrenal cortex which is caused by vitamin deficiencies could, it appears to me, disturb the normal functioning of the adrenal. The histologic structure of the adrenal cortex is often so changed by hypertrophy and hyperplasia that three layers of cells can no longer be distinguished, and the cells may not contain any lipoid material. When there is extreme hypertrophy of the adrenals, hemorrhage frequently occurs into the cortex, and may be severe enough to destroy the adrenals, causing death. If the vitamin deficiency is corrected, the three layers of cells of the cortex may reform so that the cortex regains a normal structure and appearance.

Hypertrophy of the cells of one part of the adrenal cortex may affect other cells in the cortex. Cortical cells immediately adjacent to hypertrophied cells could conceivably be similarly stimulated because the blood supply would necessarily be increased to these adjacent cells. Also, though adjacent cortical cells probably secrete hormones of similar chemical structure, if cells of one part

of the cortex are stimulated to extreme hypertrophy, it might be possible for adjacent cells to react to the same stimulus and produce an excess of a slightly different hormone with an entirely different function.

If hypertrophy and hyperplasia of one part of the cortex is extreme, the functioning of the cells of the rest of the cortex might, on the other hand, be interfered with by simple crowding. The available blood supply might be used primarily by the hypertrophic tissue. This could prevent the remaining cortical cells from producing their hormones. Histological evidence that this can happen is seen in the adrenals of stillborn infants<sup>13</sup>. Usually the inner cortical layer of the adrenals of stillborn infants is so hypertrophied that the middle and outer layers are reduced to a thin shell. Indeed, in some fetal adrenal glands, the outer and middle layers cannot be identified. Hypertrophy of the inner cortical layer may be so extreme that each gland may weigh as much as 15 gm. compared with a normal weight at birth of about 5 gm. In contrast, the adrenal glands are not hypertrophic, but have the same structure as the adult gland, in stillborn infants who have died as a result of birth trauma, and in anencephalic monsters.

A vitamin deficiency could, then, if the above reasoning is correct, produce disease directly and indirectly—directly by crippling enzyme systems which require the specific vitamin, and indirectly by causing hypertrophy and hyperplasia of the adrenal cortex. The excess hormones produced by the hyperplastic tissue might cause increased metabolism in several parts of the body, and the particular disease produced would depend upon which parts and functions of the body were affected.

Conversely, hyperplasia of the cortex might cause a decreased output of certain cortical hormones because of crowding. The disease produced would depend upon which functions of the body were interfered with by lack of specific cortical hormones.

If the above reasoning is correct, it may be possible to explain many diseases of heretofore unknown etiology. The exact chemical structures and functions of only a few adrenal hormones are known, so that it is impossible at the present time to determine all the diseases that could result from an excessive or deficient production of adrenal hormones. A few of the diseases that conceivably could be produced will be briefly discussed.

<sup>10</sup> Kendall, E. C.: *Vitamins and Hormones*, Vol. VI, New York, Academic Press, 1948, page 277.

<sup>11</sup> Hartman, F. A. and Brownell, K. A.,<sup>4</sup> page 69.

<sup>12</sup> Mote, J. R.: *Proceedings of the First Clinical ACTH Conference*, Phila., The Blakiston Co., 1950.

<sup>13</sup> Benner, M. C.: *Studies on the Involution of the Fetal Cortex of the Adrenal Gland*, *Pathology* 16: 787-797, Nov. 1940.



Desoxycorticosterone controls the electrolyte composition of body fluids through its action on the kidney tubule, apparently by causing retention of sodium. An excess production of this hormone would lead to sodium retention and edema. The edema in toxemias of pregnancy is possibly due to excess desoxycorticosterone produced by the mother's and fetus's adrenals<sup>14</sup>. Edema in certain types of heart and kidney disease may also be due to an excess of this hormone. Diabetes insipidus could conceivably be due to a deficient output of desoxycorticosterone. We know that diabetes insipidus results when there is deficient function of the posterior pituitary. It is possible that posterior pituitary control over water and electrolyte excretion by the kidney tubule is normally mediated through desoxycorticosterone.

Corticosterone has been shown to control intracellular carbohydrate and glycogen metabolism<sup>15</sup>. Deficient corticosterone production would lead to a low glycogen content of the liver and muscle and to a low blood sugar. A low blood sugar stimulates the output of adrenalin which removes glycogen from liver and muscle to raise the blood sugar. An excess of adrenalin will cause a rise in blood pressure. It is conceivable that if corticosterone function is extremely deficient over a long period of time, enough adrenalin could be produced to cause permanent high blood pressure<sup>14</sup>. The hypertension in toxemias of pregnancy may be similarly produced.

An excess of corticosterone has been shown to cause an elevated blood sugar, glycosuria and excessive glycogen deposition in the liver. This elevated blood sugar cannot be lowered by the usual doses of insulin. It is possible that insulin resistance in some diabetics is due to excess corticosterone.

In animals and in patients with Addison's disease, adrenal cortical extracts have an effect on the heart similar to digitalis<sup>10</sup>. If there were a deficient output of this adrenal "cardiac glucoside-like" hormone, the heart's action might become weak and irregular. This could cause heart failure and auricular fibrillation. Auricular fibrillation has been found by one group of investigators to occur after adrenalectomy in experimental animals<sup>16</sup>.

<sup>14</sup> Patterson, W. B.: An Explanation of the Biological Functions of the Body in Health and Disease, unpublished, Puunene, Hawaii, May 1950.

<sup>15</sup> Kleiner, I. S.,<sup>2</sup> page 529.

<sup>16</sup> Soffer, L. J.,<sup>5</sup> page 134.

## Summary

1. Physiological functions are dependent upon cellular metabolism and cellular metabolism is dependent upon complete enzyme systems inside the cell.

2. Vitamins form parts of the enzyme systems.

3. Hormones are necessary for the enzyme systems to function, and they actively control intracellular metabolism.

4. Normal cellular metabolism is dependent upon an adequate supply of specific hormones, vitamins and enzymes as well as carbohydrates, fats, proteins and minerals.

5. Deficient cellular metabolism from any cause appears to stimulate the endocrine glands to produce more of the hormones that are used in the affected cells, in an effort to bring the cellular metabolism back to normal.

6. The adrenal cortex produces many hormones, probably hundreds, which affect many body functions.

7. A vitamin deficiency, single or multiple, leads to hypertrophy and hyperplasia of the adrenal cortex which is interpreted to show that adrenal hormones activate enzyme systems utilizing the vitamins.

8. Hypertrophy of the cells of the adrenal cortex due to vitamin deficiency may cause an excess output of some cortical hormones and a deficient output of others.

9. Vitamin deficiencies produce disease directly by interfering with enzyme systems requiring specific vitamins, and indirectly by causing hypertrophy of the adrenal cortex which results in an overproduction of some adrenal hormones. The disease produced would depend upon which physiological functions are affected by the involved hormones.

10. Water and electrolyte retention in the toxemias of pregnancy and in certain kinds of heart and kidney disease may be due to an excess of the adrenal hormone, desoxycorticosterone.

Hypertension in the toxemias of pregnancy and in certain cases of hypertensive heart disease may be due to excess adrenalin produced in response to a low blood sugar resulting from a deficient secretion of the adrenal hormone, corticosterone.

Heart-block and sudden death in patients with sub-clinical beriberi may be due to production of an excessive amount of an adrenal "cardiac glucoside-like" hormone.



# Sulfonamide Nephrosis and Its Treatment

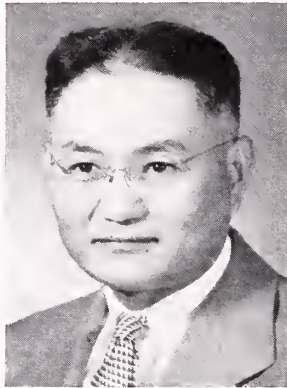
S. MIZUIRE, M.D.

HILO, HAWAII

**L**OWER nephron nephrosis has been variously designated as renal anoxia syndrome, hemoglobinuric nephrosis, crush syndrome, traumatic anuria, tubulo-vascular syndrome, etc. As the names suggest, this renal complication has appeared in conjunction with various diseases, such as severe crushing injury, mismatched blood transfusion, severe burns, uterine hemorrhage, sulfonamide intoxication, transurethral prostatic resection and other conditions associated with shock. Study of this condition was accelerated during the first World War in conjunction with crush injuries, and during the Second World War with the bombing injuries in London. Lucké first gave the name lower nephron nephrosis to this entity. Lucké placed the mortality rate near 90 per cent, and Mallory estimated the survival rate to be about 20 per cent in cases with persistent oliguria and hypertension.

Clinically, lower nephron nephrosis may be divided into several phases. Initially, there is the phase during which actual damage is done to the kidney. Operating hemorrhage resulting in shock, or a mismatched blood transfusion (though up to about 300 cc. of incompatible blood may be well tolerated) may produce the initial kidney damage to set the stage for the unfolding drama of kidney failure.

During the second phase increasing oliguria is noted, which may progress to complete anuria. The urine is usually acid and highly colored, and contains casts, albumin, blood and debris. Increasing azotemia may reach 80 to 100 mg. of urea nitrogen per cent during the first two days, and as high as 300 to 400 mg. per cent in five to seven days. In cases of mismatched blood transfusion or hemolysis during transurethral prostatic resection, hemoglobinemia may develop immediately,



DR. MIZUIRE

and jaundice may appear. Clinically, depending on the degree of hydration during this phase, symptoms of encephalopathy may appear. It has been repeatedly stressed in the literature that where intravenous fluids were restricted to 1,000 cc. or less per day, which is enough to cover the insensible water loss in afebrile individuals, death is less frequent; but where fluids were pushed, mental complications appeared and death due to acute pulmonary edema ensued. With carefully restricted administration of fluids and salt, it is common to see a mentally clear patient even with anuria lasting five to eight days.

During the third or recovery phase, polyuria is established, usually with a sp. gr. of 1.005 to 1.010. Large amounts of urinary salt may be excreted, as high as 40 gms. daily. Renal function may return to normal in two to four months.

## Pathology

Pathologically, the kidney is swollen. On section the cortex is pale and friable, but the medulla is injected, striated and purplish in color. Microscopically, there is anemia of the cortex and intense engorgement of the vasa recti with tubulo-vascular communications or ruptures. The glomerular tufts are essentially unchanged. There is early degeneration with focal necrosis in the distal segment of the nephron. The distal convoluted tubules and ascending limbs of the loops of Henle contain eosinophilic casts.

Baker states that in the course of 87,000 blood transfusions at the Seattle Blood Bank, there have been four deaths attributable to mismatched transfusions. Since the establishment of the branch of the Hawaii Blood Bank in Hilo in December, 1948, there has been no serious reaction in 1,726 transfusions. In 15 patients with transurethral prostatic resections since 1948 there has been no apparent hemolysis; icteric index has not been done routinely.

## Sulfonamide Renal Injury

The role of sulfonamide sensitization in renal complications is admitted, but it is more common to see actual blockage of the renal tubules by precipitated crystals, particularly in the presence of an acid urine. It has been recent practice to use combinations of several sulfonamides—sulfadia-

From The Surgical Department of the Hilo Memorial Hospital.

Read before the Hawaii Chapter, American College of Surgeons, September 16, 1950.

zine, sulfamerazine and sulfamethazine—thereby keeping the individual sulfonamide concentration low, but realizing a therapeutic effect from the combined concentration. When sulfadiazine alone is administered, crystalluria is present in 26 to 28 per cent but this can be reduced to 6 per cent by a combination of sulfadiazine and sulfamerazine. It can be lowered further when an adequate amount of alkali is added.

After eight to ten days, the regeneration of the injured renal epithelium is well under way and by three weeks it is more or less complete. If measures can be found to tide the individual over until such time as the kidney is able once again to take over its functions, a live patient might be a more frequent result. We find such therapy in the artificial kidney, and peritoneal irrigation. It requires an elaborate setup beyond the reach of most hospitals to maintain an artificial kidney, but peritoneal irrigation is available to all. With the use of antibiotics, the danger of peritonitis has been greatly reduced. A simple irrigating solution mixture, offered by Weinstock, is as follows:

0.1 gm. of streptomycin  
20,000 units of penicillin  
10 mg. heparin

added to 1000 cc. of Hartmann's solution, made hypertonic with 10% glucose solution.

The following cases illustrate sulfonamide renal complications.

### Case Reports

CASE 1.—E. A., a Caucasian boy of five, was operated on for gangrenous appendicitis April 21, 1946. At the time of closure, 2 grams of sulfanilamide powder were sprinkled into the peritoneal cavity and the wound. The postoperative course was satisfactory, except that the mother noted that the child was urinating less and less. On April 26, the child voided 10 drops of highly colored urine at 11 p.m. and in that urine, mother noted white "gravel," which was thought by the doctor to be sulfanilamide crystals. By 3 p.m. of the next day, the child had not voided any urine in spite of adequate fluid intake. At 3 p.m. he voided about 10 drops of highly colored urine, and two hours later he voided 10 drops more. Sulfonamide oliguria was diagnosed, and the child was admitted to the Hilo Memorial Hospital April 27, 1946.

On physical examination, the child was well developed, well nourished and cooperative. His temperature was 100.2 degrees, pulse 114 and respirations 24. His face was flushed, and the tongue dry. The only positive findings were confined to the abdomen where a healed recent pararectus incision in the lower right quadrant was found. Abdomen was soft and not distended. Both costovertebral angles were very tender to percussion.

The laboratory reported that the urine was alkaline and contained 2 plus albumin and occasional red and white blood cells, but no sulfa crystals. Culture of the urine gave no growth. The red cell count was 3,570,000,

with 12 gms. of hemoglobin. The white cell count was 14,000, with polys 44%, lymphs 37%, eosinophiles 4%, basophiles 1%, stabs 14%. Urea nitrogen was 19.9 mg. per cent.

The child was taken to surgery for cystoscopy. The bladder was entirely empty. Both ureters were catheterized and both renal pelvises were washed with warm saline solution. Urine immediately began to issue from both catheters. The catheters were left indwelling for three hours and then withdrawn. Within four hours after cystoscopy the child had passed 400 cc. of urine.

Sodium bicarbonate was given in 1 gm. doses q.i.d., and postoperatively 500 cc. of 5% glucose in lactate Ringer's solution were given intravenously. Recovery was uneventful.

CASE 2.—Mrs. S. T., age 34, a Japanese housewife, consulted her doctor on April 8, 1948, for acute general malaise with a temperature of 103°F. She ingested 14 tablets of 7½ grs. sulfathiazole combined with equal amount of sodium bicarbonate during the next three days. On April 9, she was admitted to one of the outlying hospitals. Her temperature reached normal in about a day but she gradually developed oliguria and on April 13, she became absolutely anuric. By then her general condition had deteriorated and she sank into a stupor. She was then admitted to the Hilo Memorial Hospital.

On physical examination, the patient was well built and well nourished with a blood pressure of 134/90, temperature 99, pulse 104 and respirations 22. She was in deep stupor. The skin and tongue were dry, and the breath was uremic. The abdomen was slightly distended. The costovertebral angles were not tender.

Four urinalyses between April 15 and April 23 showed specific gravity of 1.010, white cells, red cells, 4 plus albumin declining to a trace, and inconstant casts. No sugar or sulfa crystals were seen.

Red cell count was 3,600,000 and white cell count 18,100 per cubic mm. Hemoglobin was 11.4 gms. per 100 cc. There were 88% polys, 7% lymphocytes, 4% monocytes, 1% eosinophiles, 3% stabs.

Blood urea nitrogen April 13 was 105; it rose to 166 on April 19 and dropped to 128 on April 20 and 73 on April 23. Blood chlorides were 220 on April 14. Eagle reaction of the blood was negative.

On the night of admission at 8 p.m. on April 13, 1948, she was taken to Surgery for cystoscopy and ureteral catheterization. There was 1 cc. of dark liquid in the bladder, and the mucosa was hemorrhagic. Both ureters were catheterized. There were about 10 drops of urine in right kidney pelvis. Sulfa crystals were looked for in this urine but none found. Both pelvises were lavaged with warm normal saline solution. Catheters were left indwelling, but in the next twelve hours no urine appeared.

On April 14, patient was taken back to surgery and under local anesthesia, a Foley catheter was inserted into the peritoneal cavity in the left epigastric region. Through another incision in the left lower quadrant close to the median line, a stump drain was inserted into the cul de sac. The patient was taken back to her room and through the upper tube 5% glucose in distilled water was allowed to drip in at the rate of 60 drops per minute, while to the lower drain, constant suction was maintained. A ratio of 2,000 cc. of 5% glucose in distilled water to 1,000 cc. of 5% glucose in normal saline was used. Peritoneal lavage was main-



tained for four days. Penicillin was given, 50,000 units every four hours intramuscularly.

On April 15, 1948, 150cc. of bloody urine were obtained per catheter, and on this day, patient began to call for water. On the sixteenth, she voided 975 cc. of dark urine. On the seventeenth she voided 1375 cc. On the eighteenth, the patient was mentally clear and went on to good recovery. She was last seen September 2, 1950, feeling and looking well, with a blood pressure of 148/90 and showing only a trace of albumin in her urine.

### Discussion and Conclusion

The pathologic lesions of the kidney in lower nephron nephrosis are similar in spite of the various etiologic agents. It is difficult to see how sulfonamide intoxication can account for pathologic changes in the kidneys similar to lesions produced by a crush injury, hypotension or mismatched blood transfusion, unless there is involved a common denominator which brings about the renal changes. A search through the literature does not provide an answer but the most attractive bit of experimental evidence is that concerning the shunting of the intrarenal circulation. Trueta has shown that circulation to the cortical glomeruli can be shunted through the corticomedullary section of the kidney.

Tracy observed cortical anemia, and engorgement of the medullary portion of the kidney, when the sciatic nerve or the renal sympathetic nerves were stimulated. In shock, similar changes have been noted. With engorgement of the vasa recti, tubulo-vascular communications are produced, leading to renal shutdown.

In the first case, oliguria was clearly based on mechanical obstruction by sulfonamide crystals. In the second case, a true lower nephron nephrosis must have been present. Sulfonamide sensitivity can only be surmised. In the treatment, fluids and salts should be cautiously given, and peritoneal lavage resorted to at the appropriate moment.

### References

1. Ledbetter, J. H., and Cronheim, G. E.: Clinical Use of Triple Sulfonamide Mixture, 216:27 (July) 1948.
2. McManus, J. F. A.: Structure of the Glomerulus of the Human Kidney, *Am. J. Path.* 24:1259 (Nov.) 1948.
3. Wyatt, J. P., and Glodenberg, H.: Lower Nephron Nephrosis associated with Massive Adrenal Infarction, *Am. J. Clin. Path.* 18:653 (Aug.) 1948.
4. Muirhead, E. E., and Hill, J. M.: The Treatment of Acute Renal Insufficiency, *Surg., Gynec. & Obst.* 87:445 (Oct.) 1948.
5. Frank, H. A., Seligman, A. M., and Fine, J.: Further Experiences with Peritoneal Irrigation for Acute Renal Failure, *Ann. Surg.* 128:561 (Sept.) 1948.
6. Vermeulen, C. W., and Snead, C. R.: Effect of Renal Decapsulation in Experimental Mercury Nephrosis, *J. Urol.* 60:216 (Aug.) 1948.
7. Weinstock, H. L., and Nitsche, Jr., G. A.: Report of a Case of Lower Nephron Nephrosis Treated by Renal Decapsulation and Peritoneal Lavage with Recovery, *J. Urol.* 60:577 (Oct.) 1948.
8. Kleiman, A. H.: Sulfathiazole Anuria with Recovery following Renal Decapsulation, *J. Urol.* 56:598 (Nov.) 1946.
9. Lattimer, J. K.: A plan for the Management of Anuria, *J. Urol.* 54:312 (Sept.) 1945.
10. Corcoran, A. C., and Page, I. H.: Crush Syndrome: Post Traumatic Anuria, *J.A.M.A.* 134:436 (May 31) 1947.
11. Paxson, N. F., Colum, L. J., and Hunter, R.: Crush Syndrome in Obstetrics and Gynecology, *J.A.M.A.* 131:500 (June 8) 1946.
12. Moon, Virgil H.: Renal Deficiency Associated with Shock, *J.A.M.A.* 134:425 (May 31) 1947.
13. Gerundo, M.: On the Mode of Action of Sulfonamides, *HAWAII MED. J.* 7:118 (Nov.-Dec.) 1947.
14. Snyder, L. J.: Crystalluria Following Sulfonamide Mixtures and Sulfonamides with Alkali: A Comparative Study of 400 Cases, *J. Lab. and Clin. Med.* 32:1532 (Dec.) 1947.
15. Baker, J. W.: Low End to Side Recto-sigmoidal Anastomosis, *Arch. Surg.* 61:143 (July) 1950.
16. Tracy, E. M.: Reflex Renal Suppression, *J. Urol.* 64:63 (July) 1950.



# Intra-abdominal Neurogenic Sarcoma

BURT O. WADE, M.D.

WAIMEA, KAUAI



DR. WADE

**I**NTRA-ABDOMINAL neurogenic sarcoma comprises only a small percentage of malignant tumors occurring in the abdominal cavity, but presents many interesting and diversified features to both the surgeon and the pathologist.

These tumors arise from the abdominal autonomic nervous system. Verocay, Masson and Antoni believe they arise from the neurilemma and are neuroectodermal in origin; Mallory and Penfield feel they arise from the connective tissue (endoneurium) and are of mesodermal origin; Ransom and Kay<sup>1</sup> and others believe that in the present state of our knowledge, one cannot state with certainty the exact site of origin for both types of tissue are said to form similar intercellular substances and to have the same histologic architecture.

Pre-operative diagnosis of these tumors in the stomach may be difficult. The outstanding symptoms are bleeding, usually chronic, resulting in chronic anemia, when the tumor ulcerates. Roentgenograms show a smooth tumor sometimes with a central crater. When the tumor occurs in the intestinal tract, it produces symptoms of chronic or sudden obstruction and is frequently the cause of intussusception. Retro-peritoneal and mesentery tumors have no characteristic symptoms. The symptoms depend upon encroachment on adjacent structures. In the absence of von Recklinghausen's disease, the final diagnosis of these cases will probably not be made until microscopic examination of the tumor has been performed.

## General Characteristics

Sarcoma of the gastro-intestinal tract comprises about 3 per cent of malignant growths in that region. Neurogenic sarcoma occurs less frequently

in the abdominal cavity and rarely in the mesentery. It does not give rise to distant metastases as frequently as other neoplasms but tends to remain locally malignant. Stout<sup>2</sup> found 74 per cent of neurogenic tumors recurred following excision but in only 20 per cent of the cases was there evidence of metastases.

The incidence, relative frequency and probable association with von Recklinghausen's disease is illustrated by the following writers: in Stewart's and Copeland's series of neurogenic sarcomas, 21 out of 104 cases (20 per cent) were associated with one or more stigmata of the generalized disease, but they did not include any neurogenic sarcomas of the mesentery<sup>3</sup>.

In 1935, Geschickter<sup>4</sup>, in his analysis of 1,472 malignant lesions of the gastro-intestinal tract, found 50 cases of sarcoma, 10 of which were "sarcoma of the nerve sheath," four in the rectum, three in the stomach, three in the small intestine. One of the cases, the tumor in the small intestine, was associated with von Recklinghausen's disease.

In 1936, Sailor<sup>5</sup> reported a case of multiple neurogenic sarcomas of the mesentery, liver and omentum which showed no evidence of von Recklinghausen's disease.

Miller and Frank<sup>6</sup>, in 1939, reported two cases of neuro-fibro-sarcoma of the jejunum, one a female, age 72, with a large lobulated medullary tumor attached to the mesenteric border of the jejunum; the second case, a male, age 47, presented a large mass beneath the ligament of Treitz, and multiple tumors of the jejunum and ilium, mesentery, and retro-peritoneal nodes. Neither case was associated with von Recklinghausen's disease.

In 1943, Shapiro and Horwitz<sup>7</sup> reported a case of solitary neurogenic sarcoma of the mesentery of

<sup>2</sup> Stout, A. P.: The Peripheral Manifestations of the Specific Nerve Sheath Tumor (Neurilemmoma), *Am. Jour. Cancer* 24:751 (Aug.) 1935.

<sup>3</sup> Stewart, F. W., and Copeland, M. M.: Neurogenic Sarcoma, *Am. Jour. Cancer* 15:1235 (July) 1931.

<sup>4</sup> Geschickter, C. F.: Tumors of the Digestive Tract, *Am. Jour. Cancer* 25:130 (Sept.) 1935.

<sup>5</sup> Sailor, S.: Neurogenic Sarcoma of the Peritoneal Cavity, *Am. Jour. Cancer* 27:729, 1936.

<sup>6</sup> Miller, A. J., and Frank, L. W.: Neurofibrosarcoma of the Small Bowel, *Annals of Surgery* 103:246 (Feb.) 1939.

<sup>7</sup> Shapiro, M. J., and Horwitz, M.: Solitary Neurogenic Sarcoma of the Mesentery, *Am. Jour. Surgery* 61:132 (July) 1943.

Read before the Hawaii Chapter, American College of Surgeons, September 16, 1950.

<sup>1</sup> Ransom, H. K., and Kay, E. B.: Abdominal Neoplasms of Neurogenic Origin, *Am. Surg.* 112:700, 1940.

the jejunum without metastases found at the time of surgery. The patient died one year and nine months later with metastases.

Hamilton, Kennedy and Herault<sup>8</sup>, in 1944, reported a case of neurogenic sarcoma of the jejunum associated with von Recklinghausen's disease (chief clinical manifestation was repeated severe hemorrhages from bowel) which was successfully resected in a white male, 37 years of age.

West and Knox<sup>9</sup> in 1948 reported eight patients operated upon for gastric tumors of nerve sheath or smooth muscle origin in their hospital. Six tumors have been classified as neurofibromas, one as a neurogenic sarcoma, one as a leiomyoma, probably malignant. The neurogenic sarcoma was removed surgically from a patient 64 years old, and he was well one year later.



Fig. 1. Roentgenographic appearance of the barium enema.

Since neurogenic sarcoma encountered in the abdominal cavity is chiefly of local malignancy, the prognosis following adequate surgical removal is comparatively good. Due to the location, odd and unusual situations in which they are apt to be found, operations of considerable magnitude are often necessary in order to insure complete removal. Nevertheless, the end result justifies the extensive procedure where feasible. However, radiation therapy has been disappointing.

### Case Report

E. T., a 71-year-old Japanese man, entered the Waimea Hospital April 20, 1949, complaining of severe cramping abdominal pains, enlargement of the lower abdomen, and no bowel movement for three days. The patient had noticed mild cramping "gas pains" in the

abdomen off and on for a month. He had noticed a gradual increase in the size of his abdomen the past three months. Two days prior to admission, he took a physic with no results except severe cramping pain in the lower abdomen which persisted until admission. He had lost 18 pounds in the past year. At no time did he have blood in his stool. Constipation had become steadily worse the past two or three years.

Physical examination revealed the following: temperature, 99.6°; pulse, 76; B.P., 130/87; weight, 89 lbs.; height, 59 inches. The patient was a small, moderately thin, elderly Japanese male. He was obviously experiencing moderate abdominal discomfort. There was a mild distention and audible peristalsis, as well as a regular, firm, slightly movable, non-tender abdominal mass rising from the pelvis to about two fingers below the umbilicus. There was a hard elongated tumor in the internal inguinal ring which protruded under the skin. Rectal examination revealed a slightly enlarged prostate and a mass, above and posterior to the prostate, which was not connected to the lower bowel. There was no tumor nor abnormal discoloration of the body surface. The red blood cell count was 3,890,000; hemoglobin 78%; white count 22,000; urine was negative. N.P.N. was 35 mgm.%; uric acid, 2.89 mgm.%.

Roentgenograms of the abdomen, in the standing position, revealed fluid and gas levels in the small intestine. A barium enema showed an essentially normal colon, moderately displaced by a soft-tissue mass in the lower abdomen (Fig. 1).

I. V. pyelograms demonstrated normal functioning kidneys and a compressed bladder (Fig. 2).



Fig. 2. Roentgenogram. Lipiodol injected into cavity of large mass, May 9, 1949.

The patient refused surgery for five days, and his condition gradually deteriorated.

April 26, under low spinal anesthesia, a 2½-inch low midline incision was made. A tense blue cyst lay against the abdominal wall, covered by an adherent coil of small intestine. Aspiration of the cystic tumor revealed dark, bloody fluid. As the cyst was aspirated, severe bleeding from it caused the patient to go into profound shock. A wedge of tissue was taken from the wall of the cyst and the cavity packed with gauze. This relieved his bowel obstruction.

<sup>8</sup> Hamilton, J. B., Kennedy, P. C., and Herault, P. C.: Neurogenic Sarcoma of the Jejunum Associated with von Recklinghausen's Disease, *Ann. Surgery* 119:856 (June) 1944.

<sup>9</sup> West, J. P., and Knox, G.: Neurogenic Tumor of the Stomach, *Surgery* 23:450 (Mar.) 1948.

The pathologist reported the histologic examination of the wedge of tissue removed as "inflammatory tissue."

May 9, 1949, the cavity within the tumor was filled with lipiodol. A.P. and lateral roentgenograms demonstrated size and position of the tumor (Fig. 3).

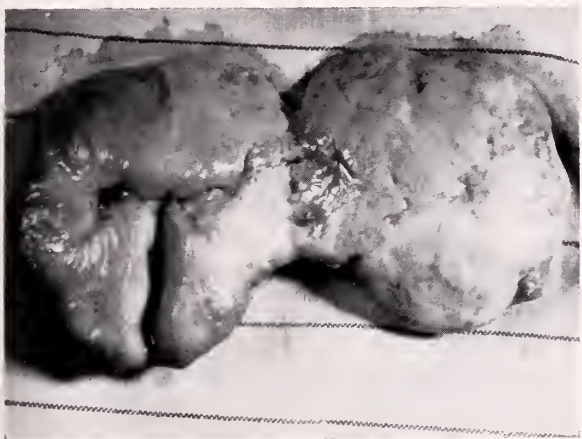


Fig. 3. Section of tumor from mesentery of the ileum showing areas of necrosis and hemorrhage.

Two weeks later, following supportive therapy, the abdomen was explored and five tumors removed: one 1 inch by 2 inches from the right internal inguinal ring attached to the peritoneum; three, almost spherical, soft, encapsulated tumors, ranging from 1 inch by 4 inches in diameter, from the mesentery of the jejunum

and ileum; and an irregular mass 3 inches by 4 inches located in the lower abdomen and pelvis which was adherent to the sigmoid, several loops of jejunum, the bladder and the prostate. No metastasis to lymph nodes nor to the intra-abdominal organs could be found.

Pathologist's Report:—"Upon sectioning, a very soft, fleshy, seemingly well-encapsulated tumor is disclosed which has a white cut surface and many areas of necrosis and hemorrhage.

"Histologic Examination:—The tumor is of mesodermal nature, being made up of elongated and spindle-shaped cells.

"The nuclei of these cells have a very definite rhythmic arrangement which is highly suggestive of a neurogenic origin. There are relatively few mitotic figures, but we believe, nevertheless, that this neoplasm is malignant."

Diagnosis: "Neurogenic Sarcoma."

The patient made an uneventful recovery. One year later, prior to leaving for the Orient, he was in excellent health and had regained his normal weight.

### Summary

A brief discussion of intra-abdominal neurosarcomas and a review of current literature on them is presented.

The prognosis of intra-abdominal neurosarcomas is good with adequate surgical removal of the tumor.

A case of multiple intra-abdominal neurogenic sarcomas, in a Japanese man, is reported.



# Hodgkin's Disease Controlled by Chloromycetin

## Report of a Case

SAMUEL R. BROWN, M.D.

HILO, HAWAII

IN 1832, Dr. Thomas Hodgkin described some cases, some of which are now considered to have been what we classify today as Hodgkin's disease. In 1898, Sternberg described what he considered then, but not later, to be "a peculiar form of tuberculosis masquerading as pseudo-leukemia." He described in detail the characteristic giant cells. In 1902, Dorothy Reed described the pathology on which our present pathological diagnosis is based. The names are coupled in the Reed-Sternberg cell.



DR. BROWN

It was interesting to look this condition up in the textbooks of my student days. The lines of battle were even then drawn as to whether it was an infection or a neoplasm and the favorite name given to it by English authors was lymphadenoma, which connotes a rather more benign process than it has proven to be.

Today, the disease is most often classed with the leukemias as a neoplastic disease. One author in Nelson speaks of "Hodgkin's paraganuloma," "Hodgkin's granuloma," and "Hodgkin's sarcoma" with reasoning that I find it hard to follow for the differentiation or the transformation of one into the other. Boyd's *Pathology* frankly separates Hodgkin's granuloma and Hodgkin's sarcoma, believing one to be infectious and the other to be neoplastic. Another writer escapes from this impasse by putting it in an intermediate position. I will not attempt to compose these various differences. An essential criterion for diagnosis is the presence of the Reed-Sternberg cell. Ewing, in *Neoplastic Diseases*, concludes: "... until the cause is determined, the question of classification is open."

This disease usually begins as an enlargement of a group of glands, most frequently cervical, though some claim the mesenteric glands are most

often the primary site. In its progress, it may invade any organ and through this invasion, or by pressure from glandular masses, may produce any chain of symptoms. In one occasional type there are no enlarged glands and diagnosis is made by finding typical Reed-Sternberg cells in the bone marrow.

To briefly mention its relation to tuberculous adenitis, there is no doubt in the remote past that the two conditions have been greatly confused. In looking back, I believe I have seen extensive cervical dissections for tuberculous adenitis when the condition was quite possibly Hodgkin's. I think it has now been quite definitely settled that there is no necessary relationship between the two conditions.

Treatment has been various. At one time surgical extirpation of the glands was frequently done. Not so now, although some still advocate it as effective treatment. Splenectomy has also been used and discarded.

X-ray therapy has been the standard treatment in recent years with varying results and shorter or longer remissions. Most recently, one of the nitrogen mustards has been used to replace or supplant x-ray therapy.

### Case Report

An unmarried woman, age 23 years, was first seen by me on July 5, 1949, with a swelling in the left side of the neck under the sternomastoid near its mastoid insertion. The naso-pharynx was negative. There were no notable glands elsewhere, no palpable spleen, or other positive findings. Chest roentgenogram was negative; blood count: red cells 4,800,000, Hgb. 84%, white cells 11,050; differential: segmented neutrophils 76%, lymphocytes 20%, eosinophils 4%. Sedimentation rate was high normal. Tuberculin tests—PPD and patch test—were negative.

She had had, shortly previous to being seen, a respiratory infection of the type which was prevalent at that time and which was variously considered, most often as a virus influenza. Although she had recovered from this, the neck condition was thought of as an inflammatory adenitis secondary to this former infection. Infectious mononucleosis was also considered and rejected after laboratory tests.

On July 8, she was put on chloramphenicol (chloromycetin), .75 gm. every six hours for three days, then reduced to .5 gm. every six hours.

On July 13, her WBC was 5,000 with a differential

Read before the sixtieth annual meeting of the Hawaii Territorial Medical Association, Hilo, May 5, 1950.

of segmented neutrophils 60%, lymphocytes 34%, eosinophils 2%, and monocytes 4%.

On July 16, chloromycetin was reduced to .5 gms. every six hours.

On July 23 she reported with loss of appetite and flatulent indigestion. The tongue was covered with a black coating. The swelling and glands had disappeared except for a suggestion of thickening. Chloromycetin was discontinued.

On September 17, patient reported that the swelling had been returning in the neck over the past two weeks. The findings were as on the first occasion with the addition of a gland anterior to the sternomastoid at the angle of the jaw. Blood picture this time was WBC 7,800, segmented neutrophils 46%, bands 6%, eosinophils 2%, lymphocytes 42%, and monocytes 4%.

On September 24, she was again given chloromycetin .5 gm. every six hours.

On October 7, glands under the sternomastoid were not palpable. The anterior gland was smaller. Chloromycetin was continued.

On October 22, the glands at the angle of the jaw were diminished and shotty; size of "two peas." The mass of glands under the sternomastoid had disappeared. Chloromycetin was discontinued.

From November 1 to 10: upper respiratory infection again of the prevalent type. There was no notable gland enlargement.

On January 16, 1950, two and a half months later, patient was seen again when she reported with a recurrence of the glandular enlargement in the same region but now, in addition, they extended down the neck in the posterior triangle of the clavicle. Chest x-ray at this time suggested diminished radiance at the extreme left apex. This was considered as not being due to pathology in the lung parenchyma but to extension in the glands behind the apex. There was no mediastinal enlargement or other new finding.

On January 18, glands were removed for pathologic examination. These glands were very friable with thin capsules. The gross appearance on cutting resembled the embryonic tissue we associate with fast-growing sarcoma. The pathological report from The Queen's Hospital was as follows: "Histologic examination of the lymph node shows a diffuse hyperplastic lesion with a general tendency toward the obliteration of the architecture. Scattered through the node are many large vesicular nuclei which sometimes override each other. These are of Dorothy Reed type. There is, in addition, a rather marked degree of eosinophilic infiltration, with one small area of necrosis. Diagnosis: Hodgkin's disease."

About this time, we saw a preliminary report from the Memorial Hospital of New York on the possible benefit of ACTH in this group. We were in correspondence with a member of the staff of Memorial Hospital, who, with others, reviewed the history and the sections were reviewed by the pathological department who agreed with the diagnosis of Hodgkin's disease. At the time we were in touch with Memorial Hospital, we also communicated with a staff member of Mayo Clinic who reviewed the case and the sections were examined by a senior pathologist who made a diagnosis of "lymphosarcoma, Hodgkin's type." Neither Mayo nor Memorial Hospital advised treatment with ACTH or Cortisone. Both agreed with the further use of chloromycetin.

On January 27, chloromycetin was begun again.

By early April, the glands were reduced by about 50%. This was definite, but much slower than on the first two occasions.

From April 11 to 15, a four-day course of one of the nitrogen mustards, "Mechlorethamine Hydrochloride Merck," was given. Dosage of 0.1 mgs. per kilogram for four successive days. This was given by the advised technic. Patient was nauseated and unhappy the days it was given and there was a minor thrombosis in one of the veins used. She also complained of suboccipital headache which passed off in a few days. There was no notable immediate effect on the blood picture. Chloromycetin was continued after the nitrogen mustard.

On April 26, there was one palpable gland under center of the sternomastoid; others had disappeared. The RBC was 4,200,000, Hgb. 88%, WBC 4,400 with a differential count of segmented neutrophils 52%, non-segmenteds 12%, eosinophils 12%, lymphocytes 24%.

Last seen on May 3. The one gland was still present but smaller. She is still on chloromycetin.

As of this time (April, 1951), the above patient is in excellent general health with a normal blood picture.

There was a residual thickened node in the neck in July, 1950. She was not seen by me until February, 1951. Since then no glandular enlargement has been found. During that time she was continued on chloromycetin.

### Deductions

Chloromycetin can be given over a long period of time without apparent ill effects.

In this case, it had a definite effect in resolving the glands of Hodgkin's disease.

Would this result tend to transfer this case of Hodgkin's Disease from the neoplastic to the infectious group, or, conversely show that this antibiotic, chloromycetin, has an effect on the metabolism of neoplastic cells?

My future procedure on the basis of this case would be first—biopsy where the cause of glandular enlargement is not evident, with long continued treatment by chloromycetin, accompanied in suitable cases with the surgical extirpation of the enlarged glands.

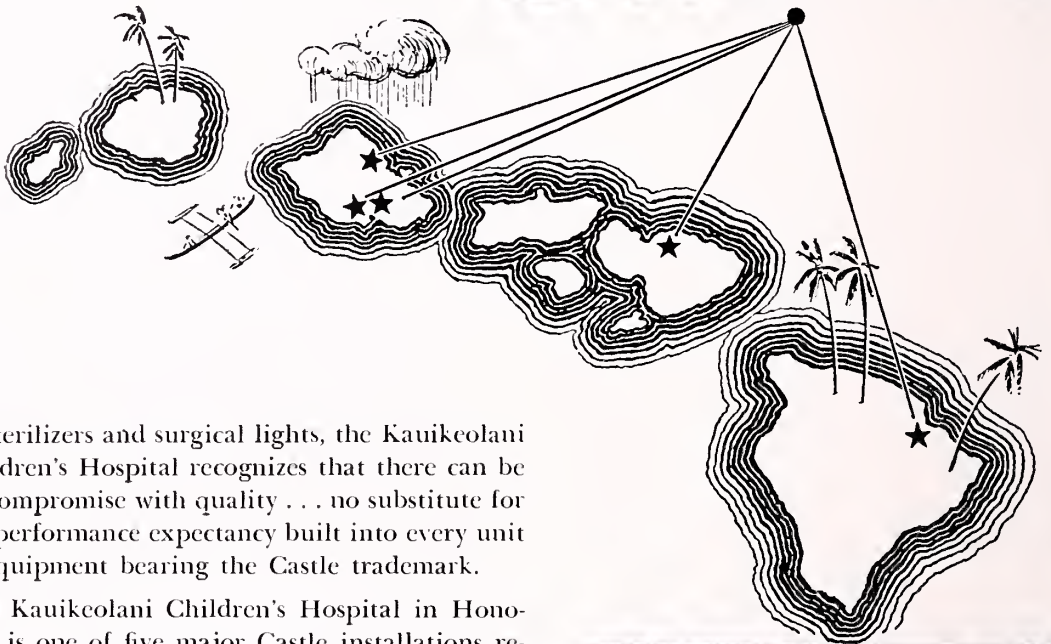
The analogy to the early use of streptomycin in tuberculous adenitis is suggestive. Is there some chemical agent such as PAS which may act as a synergist here also? In this case the nitrogen mustard may be considered to have been the synergist. However, it is far from ideal on account of its extreme toxicity and the short periods it can be used.

Would the x-raying now of former gland areas be advisable—comparable to post-operative radiation in cancer of breast?

These are fascinating questions. I have no answers or probable opportunity to obtain them. This is precisely why I have made this report in the hope that others, some of you, given the clinical opportunity, may add your check to these observations.

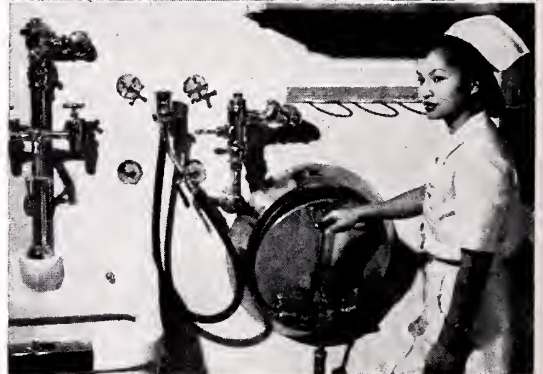
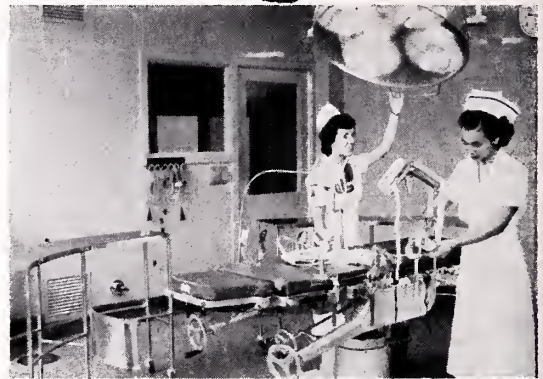
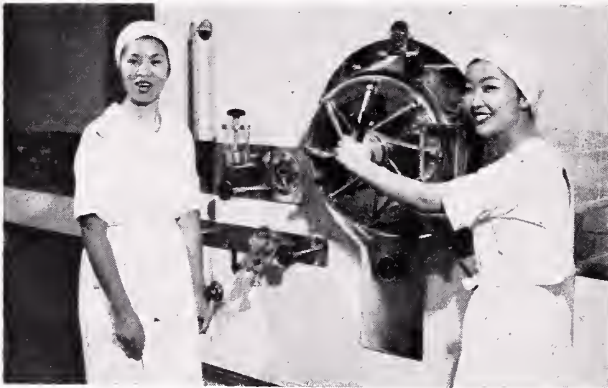


# Hawaii goes *Castle*



In sterilizers and surgical lights, the Kaulikeolani Children's Hospital recognizes that there can be no compromise with quality . . . no substitute for the performance expectancy built into every unit of equipment bearing the Castle trademark.

The Kaulikeolani Children's Hospital in Honolulu is one of five major Castle installations recently made in this vitally important part of our country.



## **To Hospital Architects and Consultants:**

We offer the experienced know-how of our Planning Department as a gratis service. We welcome the opportunity to aid in the development of any project ranging from a small sub-sterilizer room to a large medical center.

**HOTEL IMPORT COMPANY**

Division of the Von Hamm-Young Co., Ltd.

Cooke and Kawaiahao Streets

# *Castle*

**STERILIZERS AND LIGHTS**



# Hawaii

# MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D.	Editor
MRS. EDITH C. BENNETT	Managing Editor
LAURENCE M. WIIG, M.D.	News Editor
HASTINGS H. WALKER, M.D.	Advisory Board
HOMER IZUMI, M.D.	Advisory Board
PETE OKUMOTO, M.D.	Associate Editor, Hawaii
EDWARD S. KUSHI, M.D.	Associate Editor, Kauai
C. H. ISHII, M.D.	Associate Editor, Maui

## [ EDITORIALS ]

### PAN-PACIFIC SURGICAL CONGRESS — 1951

**The Fifth Congress of the Pan-Pacific Surgical Association will meet in Honolulu November 7-19, 1951.**

**All countries bordering on the Pacific Ocean are cordially invited to send representatives to this meeting, where they will meet and become acquainted with prominent surgeons from many Pacific countries.**

**All surgical specialty sections will be represented on the scientific program. Breakfast round table discussions will be held daily and motion pictures on surgical subjects shown.**

**If interested in displaying a scientific exhibit, contact Dr. J. Warren White.**

### BCG VACCINE

General use of BCG vaccine in the U.S.A. is not warranted and should not be encouraged, says the Council on Pharmacy and Chemistry of the A.M.A. in a release published December 9, 1950.

The American Trudeau Society's report on BCG is quoted at length in the report; briefly, they decided that (1) properly prepared BCG vaccine, properly administered, is harmless; (2) protection afforded is incomplete and of uncertain duration; (3) persons unavoidably exposed to known tuberculosis apparently derive considerable protection from its use; (4) commercial production of an approved, standard BCG vaccine is desirable; (5) BCG vaccine offers no substitute for present approved methods of reducing the morbidity of tuberculosis; and (6) BCG vaccination should be regarded as a supplement to these approved methods.

Opinion is still divided regarding both the efficacy and the safety of BCG vaccine. Some question its safety in infants. Its regular induction of a positive Mantoux in Mantoux-negative persons

proves only that it accomplishes sensitization, not that it induces immunity. Moreover, this phenomenon might be a serious drawback, since it would render the Mantoux useless as a test for determining whether infection had occurred or not, in vaccinated groups.

The experimental use of the vaccine in selected groups of non-reactors who are unavoidably exposed to the disease is all that can be recommended at the present time, the Council believes. Only if the vaccine can be improved in effectiveness, and better standardized, will its wider use be justifiable.

The Tuberculosis Advisory Committee of the Hawaii Territorial Medical Association concurs in the Council's stand on BCG and feels strongly that there is no place for its general use in the Territory's tuberculosis control program. Even limited use in Hawaii in individuals particularly exposed to infection with tuberculosis is open to question because of technical difficulties; and while not proscribing its use in such special instances, the Committee urges that it be consulted by any physician who contemplates BCG vaccination.

### THE LEAHI HOSPITAL REPORT, 1950

The medical and nursing staff of Leahi Hospital continue to make this institution a source of real pride to this community. The report is an instructive one, far too detailed to be discussed item by item, and well worth reading in the original.

Under the competent management of Dr. Paul Gebauer, the use of thoracic surgery is increasing; 95 thoracoplasties were done on 61 patients during the past year, as compared to an average of 87 operations on 52 patients during each of the past four years—with no deaths in the last 348 operations. Resection of the lung for tuberculosis has been done on 26 patients during the past year. Dermal grafting of main bronchial stenoses, an operation devised by Dr. Gebauer, has been done in 10 patients during the past four years.

Chemotherapy, chiefly streptomycin or dihydrostreptomycin plus para-aminosalicylic acid, is increasing rapidly, somewhat at the expense of collapse therapy. The rapidity of this trend is viewed with some misgivings by Dr. Perlstein, and it seems likely that the pendulum may swing a little the other way in the future.

The hospital census, like the general population, is growing older; a third of the 387 admissions during the year were 45 or over. Roughly one-third of all these were re-admissions. There were fewer far advanced cases than in the preceding year, but many more in the moderately advanced category.

Dr. Walker, Dr. Perlstein, Dr. Gebauer, and the nursing and technical staff of Leahi Hospital, as well as the Board of Trustees, are to be warmly congratulated on doing not merely a good job, but a better job every year. They have gained national recognition for Hawaii as a place where tuberculosis is managed with outstanding competence.

### "TERMS OF SLAVERY"

A physician in Sheffield, England, writing in a recent issue of the *British Medical Journal's* correspondence section, says "it is strange that there are many doctors who cannot define any dissatisfaction with the N.H.S. Act except some vague feeling that the remuneration is inadequate. The events of the past 10 years have so trained us that we no longer protest or reason why as our liberties are cancelled and our wills subjected to the will of the administrator and all-powerful political remote-control."

He then mentions three recent resignations of physicians from the National Health Service, and quotes one as follows: "I did not realize when I signed my contract that I had signed away my

civil liberty to the extent that I had done. To be condemned on the unsupported word of a woman, *not on oath*, without the normal protection of the law, is more than I can tolerate." This doctor had, the Sheffield physician goes on to relate, five complaints brought against him. Four were baseless; on the fifth, he was reprimanded because he had asked for a child to be brought to the surgery instead of visiting it!

"Every day" (the letter continues) "every doctor in the Service risks being the victim of any one of his patients' complaints, real or frivolous, made to the executive council. He can be tried, condemned, reprimanded, and fined sums of money on the evidence of any one of his patients who feels aggrieved on account of some transgression or omission on the part of the doctor. But, however unreasonable the patients are, the doctor has no redress whatever. A patient can call him at two in the morning 10 miles into the country for the pleasure of telling the doctor that he would like a prescription for cotton-wool. The doctor can do nothing but have the patient removed from his list and so deprive his family and himself of a few more shillings of his dwindling income."

This is one phase of the British experiment in what Mr. Ewing and Mr. DeVoto and Dr. Frothingham and others tell us is not socialized medicine. Are we to suppose that the British, with their years of experience in this sort of thing, are doing it less well than we would do it? It hardly seems likely.

### CONGRATULATIONS, GENERAL PRACTITIONERS!

Formal affiliation of the Territorial Academy of General Practice with the parent national organization was accomplished, charter and all, during a post-convention tour which followed the San Francisco meeting of the latter. This event is a milestone in the history of the Hawaii Chapter of the Academy, which has been such an active and vigorous organization during the period of its existence.

The officers of the local chapter are listed in the *Notes and News* section of this issue of the JOURNAL, together with an account of the annual meeting and the post-convention tour. The general practitioners are to be congratulated on their organization and conduct of the tour and the festive meeting around which it was centered, and on their national recognition as a chapter of the Academy of General Practice. Dr. A. Leslie Vasconcellos, new President of the local chapter, has a real responsibility on his hands in the guiding of this young organization during the coming year.

# MEDICAL NEWS

Preliminary work indicates that **DOCA** (desoxycorticosterone acetate) up to 15 mg. a day sublingually helps to control **convulsive seizures**, both grand mal and petit mal, when used in conjunction with other standard anti-convulsive drugs. Whether or not this action of DOCA is due to the sodium-retention it causes has not been proved. (Aird and Gordon, *J.A.M.A.* 145:715 [Mar. 10] 1951.)

**Neomycin** is an unusually useful **intestinal antiseptic**, according to Poth, *et al.* (Univ. Texas). Like other antibiotics it will produce a sterile bowel for elective operations, but incredibly enough, Neomycin is so bactericidal that when it is injected by gastric tube in an acutely obstructed patient, it will completely destroy all intestinal bacteria within an hour or two, making open anastomosis possible. Sulfathalidine is given with Neomycin to eradicate aerobacter aerogenes which occasionally escape the Neomycin. Dosage is 1.0 gm. Neomycin and 1.5 gms. sulfathalidine, q 4 h. The great audiotoxicity of Neomycin is no problem because of the short period of administration. (*South. Med. J.* 44:226 [Mar.] 1951.)

The blind loops which are sometimes created in **intestinal anastomoses** may give rise to a **normochromic anemia** resistant to treatment. This anemia is invariably fatal in experimental animals, but can be prevented with **aureomycin**. (Toon and Wangenstein, *Proc. Soc. Exp. Biol. & Med.* 75:762 [Dec.] 1950.)

**ACTH** induces high urinary excretion of ascorbic acid. Occasionally a **hemorrhagic diathesis** will result, as in two cases reported by Stefanini and Rosenthal (*Proc. Soc. Exp. Biol. & Med.* 75:806 [Dec.] 1950). It would seem that large doses of vitamin C should be added to the list of things to be given (potassium salts, long-acting penicillin, and testosterone) whenever ACTH therapy is prolonged.

Chamberlin finds **Bentyl hydrochloride** (Merrell) a more powerful **antispasmodic** than Trasentine, Pava-trine and papaverine. It has  $\frac{1}{8}$  the potency of atropine and none of the drying effect. Relief was obtained in all but 11 of 71 patients with functional digestive diseases and primary dysmenorrhea. (*Gastroenterol.* 17:224 [Feb.] 1951.)

A derivative of cortisone,  **$\Delta 4,6$ -dehydrocortisone**, is much better tolerated by experimental animals, and does not have the lymphocyte-depressing effect of cortisone, according to Higgins, Woods and Kendall (*Endocrinol.* 48:175 [Feb.] 1951).

Henderson, *et al.*, reports that giving **insulin with cortisone** to patients with **rheumatoid arthritis** makes it possible to get good results with much less cortisone. (*J. Clin. Endocrin.* 11:119 [Feb.] 1951.)

**Methylandrostenediol** ("Stenediol"-Organon) is a **non-virilizing androgen**. It has the anabolic effect of testosterone (weight gain, muscle growth) without the virilizing side effects which are so undesirable in women and children. It has been found useful in osteoporosis (abolishing pain and hypercalcuria) and in metastatic breast cancer. Dosage: 40 mg. per day sublingually. (Gordon, *et al.*, *J. Clin. Endocrinol.* 11:209 [Feb.] 1951.)

**Antabuse** is useful in the treatment of alcoholism but several deaths have followed its use. Antabuse blocks the liver breakdown of acetaldehyde, a normal product of alcohol metabolism. The rise in blood acetaldehyde causes uncomfortable palpitation, flushing of the face, and a sharp fall in blood pressure, especially diastolic. Iron salts (**ferric chloride**) given intravenously in small amounts have been found to be an effective antidote against Antabuse. (Christensen, *Quart. J. Stud. Alc.* 12:30 [Mar.] 1951.)

**Adrenoxyl** greatly decreases blood loss from experimental surgical wounds (Hagerty, *et al.*, *Arch. Surg.* 62:420 [Mar.] 1951). It **diminishes oozing** from capillaries, venules and arterioles, but does not, of course, check brisk bleeding. Adrenoxyl is the semicarbazone of adrenochrome, a powerful but unstable hemostatic agent which is an oxidation product of epinephrine.

**Chloramphenicol** interferes with the bactericidal action of penicillin, according to Jawetz, *et al.* (*Arch. Int. Med.* 87:349 [Mar.] 1951.) Similar "**antibiotic antagonism**" has also been found between penicillin and other "new" antibiotics, aureomycin and terramycin. It does not occur with bacitracin.

Subcutaneous **injection of procaine penicillin** directly under the involved areas gives remarkable results in chronic **syphilis vulgaris** and **hidradenitis suppurativa**, according to Belson (*Arch. Derm. & Syph.* 63:380 [Mar.] 1951.)

Finnerud and Riddell say that polythionic acid ("**Dermasulf**," Carroll Dunham Smith) is superior to any other sulfur preparation in the treatment of **acne** and **seborrheic dermatitis** because the water-soluble polythionic acids penetrate the skin more easily. (*Arch. Derm. & Syph.* 63:373 [Mar.] 1951.)

C. A. DOMZALSKI, JR., M.D.



# THE HONOLULU COUNTY MEDICAL LIBRARY

---

MRS. ETHEL HILL, *Librarian*  
MISS KATHERINE NEWHALL, *Assistant Librarian*  
Phone 6-5370  
8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.  
Monday through Friday  
Closed Saturdays at noon and Sundays  
Closed all day and evening on National holidays  
and at noon on Territorial holidays

## RECENT ACQUISITIONS

### Alcoholism

Alcoholics Anonymous *An interpretation of the twelve steps of the A.A.A. program.* c1946. (gift of Dr. Devereux)

### Atomic Medicine

Armed Forces Special Weapons Project *Radiological defense.* v.3. 1949. (gift of Dr. Faus)

### Biochemistry

Mackenzie, C. G., ed. *Biological antioxidants.* (Transactions of the 4th conference, Dec. 8-9, 1949) 1950. (gift of Josiah Macy, Jr., Foundation)

Reifenstein, E. C., ed. *Metabolic interrelations.* (Transactions of the 2d conference, Jan. 9-10, 1950) 1950. (gift of Josiah Macy, Jr., Foundation)

### Cancer

Cantril, S. T. *Radiation therapy in the management of cancer of the uterine cervix.* c1950. (gift of publisher)

Farber, S. M. *Cytologic diagnosis of lung cancer.* c1950. (gift of publisher)

Potter, V. R. *Enzymes, growth and cancer.* c1950. (gift of publisher)

White, W. C. *Cancer of the breast.* c1930. (gift of Dr. Devereux)

### Cardiology

Ashman, Richard *Essentials of electrocardiography.* c1937. (gift of Dr. H. M. Patterson)

Brooks, Harlow *Angina pectoris.* c1929. (gift of Dr. Devereux)

Edwards, E. A. *Thrombosis in arteriosclerosis of the lower extremities.* c1950. (gift of publisher)

### Clinical Medicine

Herrmann, G. R. *Methods in medicine.* 2nd ed. rev. c1950. (gift of publisher)

### Diagnosis

Baur, H. L. *Urgent diagnosis.* c1950. (gift of publisher)

### Digestive System

Alvarez, W. C. *The mechanics of the digestive tract.* c1922. (gift of Tripler General Hospital)

### Drugs

Baer, K. A. *The pituitary-adrenocortical function: ACTH, Cortisone, and related compounds: a bibliography.* 1950. (gift of Army Medical Library)

Beyer, K. H. *Pharmacological basis of penicillin therapy.* c1950. (gift of publisher)

Mote, J. R., ed. *Proceedings of the first clinical ACTH conference.* c1950.

Spink, W. W. *Sulfanilamide and related compounds in general practice.* c1941. (gift of Dr. Devereux)

### Endocrinology

Kenyon, H. R. *The prostate gland.* c1950. (gift of publisher)

Nesbit, R. M. *Your prostate gland.* c1950. (gift of publisher)

Turner, H. H. *The clinical use of testosterone.* c1950. (gift of publisher)

Wilkins, Lawson *The diagnosis and treatment of endocrine disorders in childhood and adolescence.* c1950. (gift of publisher)

Williams, R. H., ed. *Textbook of endocrinology.* c1950. (gift of publisher)

### First Aid

Murray, C. R., ed. *Treatment of injury.* 2v. c1929-31. (gift of Dr. Devereux)

### Geriatrics

Shock, N. W. *A classified bibliography of gerontology and geriatrics.* c1951. (gift of Forest Park Foundation)

### Hematology

Clough, P. W. *Diseases of the blood.* c1929. (gift of Dr. Devereux)

Flynn, J. E., ed. *Blood clotting and allied problems.* (Transactions of the 3rd conference, Jan. 23-24, 1950) 1950. (gift of Josiah Macy, Jr., Foundation)

### History

Sigerist, H. E. *A history of medicine.* v.1. c1951.

### Kidney

Bradley, S. E., ed. *Renal function.* (Transactions of the 1st conference, Oct. 20-21, 1949) 1950. (gift of Josiah Macy, Jr., Foundation)

Campbell, M. F. *Infections of the kidney.* c1931. (gift of Dr. Devereux)

### Leprosy

Monrad-Krohn, G. H. *The neurological aspect of leprosy.* (gift of Dr. Larsen)

### Nursing

Wensley, Edith *The community and public health nursing.* c1950. (from Nurses' Association)

**Obstetrics & Gynecology**

- Eastman, N. J. *Williams' obstetrics*. 10th ed. c1950. (gift of publisher)  
 Titus, Paul *The management of obstetric difficulties*. 4th ed. c1950. (gift of publisher)

**Ophthalmology & Otorhinolaryngology**

- Atkinson, T. G. *Technic of refraction*. c1922. (gift of Dr. Van Poole)  
 Lewis, G. G. *The ophthalmic formulary*. c1942. (gift of Dr. Van Poole)  
 Proetz, A. W. *The displacement method of sinus diagnosis and treatment*. c1931. (gift of Dr. Van Poole)  
 Van Alyea, O. E. *Nasal sinuses*. 2nd ed. c1951.  
*Year Book of the Eye, Ear, Nose and Throat*. 1949. (gift of Dr. Van Poole)

**Orthopedics**

- Colonna, P. C. *Regional orthopedic surgery*. c1950. (gift of publisher)

**Pathology**

- Russell, D. S. *Observations on the pathology of hydrocephalus*. 1949.  
 U. S. Naval Medical School, Bethesda, Maryland, *Color atlas of pathology*. n.d. (gift of publisher)

**Pediatrics**

- Jackson, E. B., ed. *Family centered maternity and infant care*. (Supp. I.—Transactions of the 4th conference, 1950) 1950 (gift of Josiah Macy, Jr., Foundation)  
 Spock, Benjamin *The pocketbook of baby and child care*. c1946. (gift of Dr. Devereux)

**Respiratory System**

- Gray, J. S. *Pulmonary ventilation and its physiological regulation*. c1950. (gift of publisher)

**Social Psychology**

- Senn, M. J. E., ed. *Symposium on the healthy personality* (Supp. II. Transactions of the 4th conference, March 1950) 1950. (gift of Josiah Macy, Jr., Foundation)  
 Wanters, Jane *Achieving maturity*. c1949. (gift of publisher)

**Surgery**

- Coller, F. A. *Indications for and results of splenectomy*. c1950. (gift of publisher)  
 New, G. B. *The use of pedicle flaps of skin in plastic surgery of the head and neck*. c1950. (gift of publisher)

**Tropical Medicine**

- Leeson, H. S. *Anopheles and malaria in the Near East*. 1950. (gift of London School of Hygiene and Tropical Medicine)  
 Shattuck, G. C. *Diseases of the tropics*. c1951. (gift of publisher)  
 Wilcocks, Charles *Health and disease in the tropics*. 1950.

**Tumors**

- Dandy, W. E. *Benign tumors in the third ventricle of the brain; diagnosis and treatment*. c1933. (gift of Medical Group)

- Lipschutz, Alexander *Steroid hormones and tumors*. c1950.

- Norris, C. C. *Uterine tumors*. c1930. (gift of Dr. Devereux)

**Miscellaneous**

- Fay, Temple *Ambulance anecdotes*. c1933. (gift of publisher)  
 Hogg, Jabez *The microscope*. 6th ed. 1887. (gift of Dr. Van Poole)  
 McComb, S. J. *The preparation of photographic prints for medical publication*. c1950. (gift of publisher)  
 Osborne, S. L. *Diathermy*. c1950. (gift of publisher)  
*Quarterly cumulative index medicus*. v.46 (July-Dec) 1949.  
 Pusey, W. A. *The history and epidemiology of syphilis*. c1933. (gift of Dr. Devereux)  
 Woodside, Moya *Sterilization in North Carolina*. c1950. (gift of Human Betterment League of North Carolina)

\* \* \*

The "new" Chinese Medical Journal (Jan.-Feb. 1951 issue) appeared in the Library a few weeks ago. This journal, which began publication over 30 years ago, is now being printed in Peking. The Editorial stating the new policies of the Chinese Medical Association makes very interesting reading. Also, an interesting problem is posed by their indication of a desire to arrange an exchange with the HAWAII MEDICAL JOURNAL. Since the Post Office reports that no printed matter is accepted for delivery in Communist China, we will have to leave it up to them to make necessary arrangements. In any event, we trust they will continue to forward their journal to the Medical Library, so that our doctors will be able to keep abreast of medical developments in the Far East.

\* \* \*

The first volume of Henry Sigerist's History of Medicine has been received in the Library. This volume entitled "Primitive and Archaic Medicine" is the forerunner of an envisaged eight-volume work. The preface states that Dr. Sigerist retired at the age of 56 from his chair at Johns Hopkins University, and is now living on the shores of Lake Lugano, devoting his entire time to writing a general history of medicine, global in scope. If the succeeding volumes are as fine as this first one, Dr. Sigerist will indeed be making a very great contribution to medical literature.

\* \* \*

We wish to again call the attention of doctors to the change in rules and regulations which permits them to borrow bound volumes for a period of three days. No renewals are given, and a fine of five cents a day for each issue included in the volume will be charged for any lost volume. It is perhaps unnecessary to point out that in most cases this material is irreplaceable, and the Library Committee hopes that any doctor who borrows one of these bound volumes will treat it with care. Remember that the material in the Medical Library belongs to you.

# BOOK REVIEWS

## **Williams Obstetrics.**

By Nicholson J. Eastman. Tenth Edition. 696 illustrations. 1200 pp. Price \$12.50. Appleton-Century-Crofts, Inc., New York, 1950.

This new tenth edition is a welcome addition to our obstetrical library. It has been ideally outlined in sections to make it easier to read and to study. Many new illustrations have been added and definitions standardized.

The section on toxemias of pregnancy has been revised and the author re-classifies the toxemias. The same is done with placenta praevia.

Uterine inertia is dealt with amply and the newer aspects concerning its physiology and treatment discussed fully.

Discussion on midpelvic contraction has been given more space as compared to older textbooks which barely mention it.

It is highly recommended for all physicians doing any obstetrical work.

SATORU NISHIJIMA, M.D.

## **Pulmonary Ventilation and Its Physiological Regulation.**

By John S. Gray, M.D., Ph.D. 82 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

This brief monograph gives an excellent description of the physiological mechanisms governing respiration. The author shows clearly that oxygen is strongly contraindicated in morphine and barbiturate poisonings. He then progresses into a highly technical description of the details of the mechanisms of pulmonary ventilation. This book is of considerable value for the expert in the field of respiratory physiology, but leaves the novice considerably bewildered at the complex formulas used in the calculations.

RAYMOND M. DEHAY, M.D.

## **Enzymes, Growth and Cancer**

By Van R. Potter, Ph.D. 64 pp. Price \$1.85. Charles C. Thomas, Publisher, 1950.

This little book deals with intracellular physiology, especially the role of enzyme action which the author believes is the dominant factor in the organism as a whole. He believes that cancer is due to dysfunction of the intracellular enzyme action. This is not a book which is of much value to the general practitioner but of especial interest to the bio-chemist or rather the physio-bio-chemist interested in the scientific fundamentals of cancer research.

G. A. BATTEN, M.D.

## **Pharmacological Basis of Penicillin Therapy.**

By Karl H. Beyer, Ph.D., M.D., F.A.C.P. 214 pp. Price \$4.50. Charles G. Thomas, Publisher, Springfield, Ill., 1950.

Here for the first time is a monograph that summarizes our knowledge of penicillin to date in one concise clearly written book. The basic pharmacology of absorption, distribution and inactivation of penicillin is well detailed. The various dosage regimes and modes of administration are presented. The discussion of renal tubular secretion of penicillin and its inhibition is good. For those in a hurry a good summary heads each chapter.

J. L. BELL, M.D.

## **Management of Obstetric Difficulties.**

By Paul Titus, M.D. Fourth Edition. 1046 pp. with illustrations. Price \$14.00. The C. V. Mosby Company, St. Louis, Mo., 1950.

The fourth edition of Paul Titus' "The Management of Obstetric Difficulties" is perhaps the best of a series of several publications pertaining to this particular field of obstetrics, not only in the excellence of the text but in the profusion and complete adequacy of the illustrations. For those who are specialists in the field of obstetrics, there may be little new that they have not been able to gather in the journals of recent years, but to the general practitioner and those less fortunate in securing most of the journals in the field of obstetrics, this book offers a wealth of material presented concisely and in a language that is easily readable and understandable.

The chapters on Caesarean section, contracted pelvis, forceps and version and breech extraction contain pages of details which it would behoove even the specialists to read from time to time.

CLARENCE CHANG, M.D.

## **The Use of Pedicle Flaps of Skin in Plastic Surgery of the Head and Neck.**

By Gordon B. New, M.D., F.A.C.S., and John B. Erich, M.D., F.A.C.S. 104 pp. Price \$3.00. Charles C. Thomas, publisher, 1950.

This monograph is a compilation of the experiences of the Plastic Surgical Department of the Mayo Clinic in this particular field. The illustrations are numerous and excellent. The wax models of A. H. Bulbulian add to the vividness of some of the illustrated cases. Some of the defects illustrated could have been corrected with less inconvenience to the patient by other methods, but each surgeon should use the method with which he is able to obtain the best results. It should serve as an excellent reference book for anyone interested in this particular field.

WAYNE W. WONG, M.D.



**Anopheles and Malaria in the Near East.**

London School of Hygiene and Tropical Medicine, Memoir 7.

By H. S. Leeson, F.R.E.S., Major, R.A.M.C., W. H. R. Lumsden, B.Sc., M.B., Ch.B., D.T.M. and H., Lt.-Col. R.A.M.C., J. Yofe, M.D., D.T.M., Lt.-Col., R.A.M.C., T. T. Macan, M.A., Ph.D., F.R.E.S., Major, R.A.M.C. 219 pp. Price 35 shillings. H. K. Lewis & Co., Ltd., London, 1950.

The data presented in this extensive field survey of *Anopheles* and malaria in the Near East are timely. The World Health Organization has recently participated in malaria control in that part of the world. America is interested in helping the Near East solve its health problems.

The facts gathered by these careful investigators are invaluable as a working basis for malaria control. They are sketchy in most of the area covered, but this is a military survey carried out with the objective of determining places that would be safe for the troops. As a war-time survey for military purposes the field observations are more detailed and comprehensive than is usually the case. The authors showed considerable interest and a good grasp of the situation, and their contributions to a knowledge of the epidemiology of malaria in the Near East are most praiseworthy.

STEPHEN M. K. HU, Sc.D.

**Color Atlas of Pathology.**

Prepared under the auspices of the U. S. Naval Medical School of the National Naval Medical Center, Bethesda, Md. 522 pp., illustrated with 1,053 figures in color on 365 plates. Price \$20.00. J. B. Lippincott Co., 1950.

This is the first volume of a three volume set and is a readily understandable reference to general pathology, particularly from the microscopic viewpoint. The book is not a detailed reference nor is it meant to be the final word in diagnosis. It does show good representative sections, and the color reproductions are excellent. This volume discusses the diseases of the hemopoietic, reticuloendothelial, respiratory, cardiovascular, alimentary, urinary, and musculoskeletal systems, as well as those of the liver. There are 1,053 figures in color on 365 plates.

This is the first general pathological atlas by American workers in which such extensive color reproduction has been undertaken. The pictures in general are representative of the conditions depicted, but because of limitation of space are incomplete at times; also, as must be in any atlas, debatable subjects are treated sketchily. This actually enhances the value of the book to one who deals with pathology only occasionally, since it does not force him to wade through a mass of extremely technical and controversial material which would be difficult for him to evaluate.

The book is divided into sections and each section has an explanatory portion as well as an illustrated one. The print is large and legible and the colors stand out clearly. In addition, an explanatory paragraph is also present with each picture, and this makes interpretation easier. On the whole, the book is a desirable addition to a pathologist's library; a valuable addition to that of a general practitioner; and an interesting addition for any medical bibliophile.

W. HAROLD CIVIN, M.D.

**The Diagnosis and Treatment of Endocrine Disorders in Childhood and Adolescence.**

By Lawson Wilkins, M.D. 408 pp. with 411 illustrations. Price \$13.00. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

The author is an Associate Professor of Pediatrics at the Johns Hopkins University, whose postgraduate lectures on Pediatric Endocrinology, and exhibits at medical meetings, are well known.

This text will be of value to the practitioner and specialist alike, as a ready reference to endocrine problems in the younger age group. The material is organized in such a manner that the physician confronted with a problem of hormonal imbalance may quickly find the section containing the desired information. Particularly helpful are the large bibliographies at the end of each chapter.

Such common problems as obesity, growth and development, and the thyroid disorders are thoroughly treated, and of special current interest are chapters on the adrenal cortex and medulla.

Abundantly illustrated with photographs, diagrams, tables, and graphs, this book should serve to enlighten the reader on a subject that has made great strides in the past few years.

JOHN H. PEYTON, M.D.

**Thrombosis in Arteriosclerosis of the Lower Extremities.**

By Edward A. Edwards, M.D., F.A.C.S. 74 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

A remarkably concise but comprehensive presentation of the subject is made in this small monograph. In the first half the etiology and pathology, clinical picture and treatment are given with exceptional brevity and clarity.

The second half presents a series of case reports which further aid in understanding the process, the clinical findings, complications and treatment. The text is particularly well illustrated by drawings and microscopic sections, and the case reports are brief, but interesting and to the point.

This monograph is well worth reading by internists, surgeons, and all others who come in contact with patients in the age group in which arteriosclerotic changes occur.

A. V. MOLYNEUX, M.D.

**Indications for and Results of Splenectomy.**

By Frederick A. Collier, M.D., Alexander Blain, III, M.D., and Gould Andrews, M.D. 100 pp. Price \$2.25. Charles C. Thomas, Publisher, Springfield, Ill., 1950.

The experiences of splenectomies and their end-results in a variety of conditions during a fifteen year period (1934-49) are presented. The clinical features of the splenopathies treated are very briefly described and the relative difficulties and pitfalls encountered in the management and the operation are also presented. The style is concise and informative. The volume should interest anyone seeking a brief, overall information about the splenopathies usually helped by splenectomy.

T. F. FUJIWARA, M.D.

### Textbook of Endocrinology.

Edited by Robert H. Williams, M.D., with the collaboration of: Peter H. Forsham, Harry B. Friedgood, John Eager Howard, Edwin J. Kepler, William Locke, L. Harry Newburgh, Edward C. Reifstein, Jr., William W. Scott, George Van S. Smith, George W. Thorn, Lawson Wilkins. 793 pp. with 168 figures. Price \$10.00. W. B. Saunders Company, Philadelphia and London, 1950.

Very occasionally a new medical textbook is written that is worth while. This book is one of the few. The field of endocrinology has been progressing rapidly and most of the literature is confined to current periodicals. Standard textbooks of medicine are inadequate in their coverage of the endocrine glands and their diseases. There has been a need for summarization especially for those of us who are not endocrinologists. This book is the work of many outstanding men in the field. Basic physiology and clinical application of all the glands of internal secretion are well presented in an easily understood style. The chapters on adrenal physiology and pathologic physiology are especially timely in view of the current wide use of cortisone and ACTH. The book is warmly recommended to all.

J. L. BELL, M.D.

### The Community and Public Health Nursing.

Edith Wensley, New York, Macmillan Co., 1950, 250 pp., \$3.50.

Mrs. Wensley's book, undertaken for the National Organization for Public Health Nursing to take the place of the earlier Board Members' Manuals of 1930 and 1937, is a guide and reference book for the layman in public health nursing and for those who work with him. It evaluates and most wisely directs the individuals and committees whose integrated best efforts make for progress, as well as sound administration practice.

Of great importance and value is the book's broad and yet practical advice on how citizens can carry their indispensable share of the work involved in public health nursing activity. This is dealt with from the standpoint of the public health nursing service of a health department, or other governmental agency, a voluntary agency, a voluntary agency in a combination service and school boards and school nursing.

This partnership of professional and citizen strength is shown as the democratic way in which citizens can enhance and extend health services and at the same time build the public understanding of needs and of services on which adequate support can be based.

In concise and well organized fashion, the author shows the inter-relation and the inter-dependence of professional and lay leadership, and of trained staff and volunteer workers in the national, state or local community.

Sound principles of community organization are set forth with more than usual persuasiveness. Principles of administration are simply stated and their application shown directly and indirectly in the apt illustrative material throughout the book.

It is of definite value to all citizens, lay and professional, interested in the broad field of health and welfare.

ESTHER M. STUBBLEFIELD, R.N.

### Diseases of the Tropics.

By George Cheever Shattuck, M.D. 783 pp. with 157 figures and tables. Price \$10.00. Appleton-Century-Crofts, Inc., 1951.

This up-to-date and well illustrated text describes diseases of major importance in the tropics in detail, while others of less importance are more or less briefly treated. Malaria, for instance, takes 107 of the 783 pages of text. The paper, format, and printing are excellent, and the colored reproductions of the malaria parasites and flagellates are outstanding. Specific treatments of various diseases are carefully described embracing new developments up to and including 1949. The references given at the end of each chapter appear to be thoughtfully and carefully selected, and do not give one the impression of "padding." The items are arranged alphabetically according to the senior author, under each disease heading.

Criticisms are for the most part minor. The table showing malaria mortality in the United States covers only the period 1931-1941 and has been profoundly changed by the development of new insecticides. The map showing the "Malaria-free Area" in the Central and South Pacific should be titled "Anopheles-free Area." Guam, by the way, is no longer in this area.

The statement that the principal vector of dengue fever in Honolulu was *A. Albopictus* does not coincide with the observations made here, as *A. Egypti* appeared to be more important, although *Albopictus* was more abundant.

The observation on page 232: "Penicillin, doubtless, would serve for the treatment of pinta," is probably true but should be supported by facts.

The section on fish poisoning, or ichthyotoxicosis, again stresses the unproven supposition that the dumping of war materials plays an important part in such poisoning.

One surprising omission in a book of tropical diseases should be noted: there is not a single reference concerning tuberculosis.

Outside of these criticisms, the clear and concise descriptions of modern treatment, laboratory diagnosis, prevention and control of these diseases make this a valuable book for anyone interested in tropical diseases and it can be highly recommended.

J. R. ENRIGHT, M.D.

### The Prostate Gland.

By Herbert R. Kenyon, M.D. 194 pp. Price \$2.95. Random House, New York, N. Y., 1950.

The author obviously has written a book for The Public and in doing so presumably assumes that The Public will read it.

The work however contains a minute and technical dissertation on the endless signs, symptoms and sometimes questionable etiologic factors of all the known disorders of that much disordered gland. A particularly unfortunate example of this is a long and tedious description of benign prostatic hypertrophy and all its complications followed by a verbose description, in the minutest detail, of the technique of each operation presently in use for relief of this condition.

There are however some redeeming features in the book. His philosophical remarks on gerontology and on



the futility of prolonging old people's lives unless they can remain economically, sociologically, and culturally integrated into their environment, bring to mind the victim of a chronic disabling ailment who survives for years, only as an economic burden to himself, his family or the community. This particularly applies to the older with progressive obstructive prostatic disease and the author eloquently pleads for early surgical relief of this condition before irreparable damage is done.

On the whole it is difficult to see the need of such a book for the laity and almost impossible to conceive of its complete perusal or comprehension by any member of its intended audience.

P. S. IRWIN, M.D.

**Sexual Deviations.**

By Louis S. London, M.D., and Frank S. Caprio, M.D., 702 pp. Price \$10.00, 1950, Washington Institute of Medicine, Washington, D. C.

This volume serves its greatest usefulness in the presentation, with an attitude of liberalism and understanding, of material not before collected in a single volume. The sexual deviations have been described adequately before in works by Ellis, von Krafft-Ebing, and others, and there would be little value in repeating what has been said by them. The emphasis in the present volume, however, is placed upon the psychodynamics of the deviations according to psychoanalytic principles. Those principles are illustrated by detailed case histories culled from many analytic hours spent with patients. The chapter headings include homosexuality, incest, exhibitionism, frottage, sadism and masochism, fetishism, transvestism, and other deviations met with less frequently. Included is a section on general discussion, therapeutic and sociological aspects, and a good glossary, bibliography, and index.

Of less general interest is a section consisting of the analysis of 960 dreams of a female homosexual which were collected by Dr. London and given to Dr. Caprio. The latter, although he knew nothing about the patient, was able to give a correct description of her history, her physical characteristics (he had not previously known even her sex), and the symptoms and etiology of her neurosis. Interesting though this section is, the reviewer felt it was out of place in this volume, since it added little to the content or purpose and might have been published elsewhere.

CLIFTON C. RHEAD, M.D.

**The Audiology Clinic—A Manual for Planning a Clinic for the Rehabilitation of the Acoustically Handicapped.**

By Moe Bergman, Ed.D. Price \$1.00, 107 pp., The Audiology Foundation, Chicago, Illinois, 1950.

This manual offers, to lay and professional people interested in the development of a complete clinic for the hard of hearing, a sound working program for the planning, construction and operation of such a unit. Few communities or organizations can support such a clinic in its "ideal" proportions and operations. The model described is the veterans administration clinic in New York City. However, plans and suggestions for less extensive centers to rehabilitate the acoustically handicapped are contained in the monograph.

The manual will surprise the uninitiated with the extent of developments in this field, and will refresh

the otologist's memory concerning the widely diversified talents necessary to fulfill the needs of a complete "hearing center." This worthwhile and comprehensive treatise contains many references from speech therapists, acoustic physicists, architects, electronic engineers, psychiatrists, psychologists, and otologists as well as outstanding men in related fields. In essence the publication treats the application of a new specialty, audiology, which has been defined as "the science of hearing, . . . a new integrated concept of human communication."

JOHN P. FRAZER, M.D.

**Diathermy.**

By Stafford L. Osborne, B.P.E., M.S., Ph.D. 113 pp. Price \$3.00, Charles C. Thomas, Publishers, 1950.

This book, by a clear and concise summary of the evolution of short wave therapy and a clear description of the various types of short wave used in medical and surgical diathermy, together with specific specialized apparatus and details of methods of application, offers a good short reference book for the technician or physiotherapist using diathermy and an introduction to the field of diathermy as a modality in physical medicine for the medical student, nurse or doctor. The author in no way makes specific claims for the value, nor urges the use, of diathermy for any specific conditions, but rather describes the theoretical value as well as the dangers of use and abuse of short wave therapy.

IVAR J. LARSEN, M.D.

**Ambulance Anecdotes.**

By Temple Fay, M.D. 124 pp. Price \$2.50, Charles C. Thomas, 1951—Third Edition.

Ambulance Anecdotes is a story of an ambulance surgeon while on this particular service of a rather fast moving internship. The author is the distinguished neurosurgeon, Temple Fay of Philadelphia, and his style of writing makes for some very amusing humor. The book itself provides one with about an evening's leisure reading and once started will be found difficult to lay down. This is a part of routine hospital life which seldom gets before the public. This work will appeal to all and particularly those within the medical profession, for the experiences are those of every intern, most expertly put into words by the clever Dr. Fay.

JAMES G. MARNIE, M.D.

**Visual Anatomy: Head and Neck.**

By Sydney M. Friedman, M.D., Ph.D., 232 pp. with 93 illustrations. Price \$6.50. Charles C. Thomas, Publisher, 1950.

Among all the literature that has to be surveyed by the professional man, a literature which is crowded with repetitious statistics and verbose advertisements, one certainly would not expect to find any original or new ideas in a book on the anatomy of the head and neck. What, after all, can be more static than anatomical descriptions which have to be practically the same whether they are written by Gray or Spalteholz?

To say, then, that Friedman's book is different and rather original in its presentation requires some qualifying comment. Rather than give a description of tissue in the sequence in which dissection proceeds, and where the tissue is exposed from the surface layer to the deeper tissue, Friedman starts with the basic structure, the skeletal arrangement, and builds his description up



from that. It makes for a definitely better understanding of the relationship between organs.

Although the text is necessarily condensed, which again can be seen as an advantage, it rouses the interest of the medical student by offering glimpses of clinical medicine, as, for instance, in describing the brachial plexus, the function of the phrenic nerve or the control of the heart rate in relation to the vagus nerve. Very clearly shown, for instance, are the anatomic relations between the scalenus muscle and the sympathetic ganglion or those between the posterior belly of the digastric muscle and its underlying nerves and blood vessels.

For this reviewer, the book has been a pleasant and refreshing study, while it is certain to give to the graduate student a good deal of insight into the complicated structure of the head and neck.

The illustrations are remarkable, insofar as they remind one of the wood prints of Rockwell Kent, and by that particular form of presentation, they permit a good impressive image of the tissue.

Altogether, the book is commendable for anyone with a background of anatomic dissection, and with its graphic illustrations would serve as an excellent guide to the medical student. But then, who expects to learn anatomy merely from a book?

MAURICE GORDON, M.D.

### Methods in Medicine.

By George R. Herrmann, M.D., Ph.D. Second Edition. 488 pp. Price \$7.50. The C. V. Mosby Co., 1950.

This book is a concise compilation of the approach to the diagnosis of the patient. One section deals with the history and physical examinations and their ramifications. A second deals with laboratory tests, their normal value and significance. Other sections deal with tests for special conditions, therapy, and diet.

The book is well organized and the index, though short, is usable. A working outline table of contents facilitates use of this volume. Many of the tests described are new, valuable, and simple.

The book is small, the print is large and easily read. It is an excellent one for general reference. It is by no means a final authority on diagnosis, but it does give numerous hints on solving problems.

The work is not one to be taken up and read from cover to cover, but is certainly a handy reference handbook.

W. HAROLD CIVIN, M.D.

### Radiation Therapy in the Management of Cancer of the Uterine Cervix.

By Simeon T. Cantril, M.D., 189 pp. Price \$5.00. Charles C. Thomas, Publisher, 1950.

This monograph is easily and quickly read. The entire subject is well presented. Every phase in the management of uterine cervical cancer is adequately covered and all sides of controversial subjects are impartially covered. The subject of surgery versus radiation in early cancer of the cervix is presented lucidly and in a fair manner. The author's own preferences are usually stated. The bibliography is extensive. The only issue which could be taken by the reviewer is the extensive reference to European clinics in the analyses of various forms of treatment. Very few reports of American centers are cited. This may be due to the author's inclinations for radium therapy, used so extensively in

Europe, rather than the tendency in American centers to rely heavily on roentgen therapy. In all, the monograph is very worthwhile reading for all physicians treating this form of cancer. There is one very long sentence in this work, which is felt to be worthy of direct quotation, for those unable to read the entire volume. "It is our observation that in most instances radiation sickness is a disease which the patient contracts from the referring physician, whose only acquaintance with the subject has been gained from reading articles published by radiologists who have used every vitamin in the alphabet (successfully) or instituted various other measures than those which have any relation to its cause, namely, attention to the details of therapy."

PHILIP S. ARTHUR, M.D.

### Saw-Ge-Mah.

By Louis J. Gariepy, M.D. 326 pp. Price \$3.00. From Northland Press, 2642 University Avenue, St. Paul 4, Minnesota, 1950.

An entertaining, rambling yarn about a young doctor practicing in Michigan locales familiar to the author, and growing up in the process.

HARRY L. ARNOLD, JR., M.D.

### Harvey Cushing.

By Elizabeth H. Thomson. 347 pp. with illustrations. Price \$4.00. Henry Schuman, Inc., Publishers, New York, 1950.

This book is an interesting "homey" description of the life of a great man. As such it compliments the larger and more scientific biography by John F. Fulton. To those who knew Harvey Cushing it will have great appeal especially to those of us who were former students and enjoyed intimate hours with him. The only criticism of both this and the Fulton book, it seems to me, is the failure to picture the very strong human likes and dislikes which enter the personal life of every great man. Dr. Cushing loved and hated with equal strength. When E. W. Scripps, founder of the great Scripps-Howard newspaper chain, was shown the first draft of his biographic work, he threw it in the waste basket with the remark, "If you are going to write my biography put in the bad as well as the good—I am no saint." Harvey Cushing, great as he was, was also no saint.

PAUL WITHERINGTON, M.D.

### Also Received

#### The Medical Clinics of North America.

Chicago Number. Symposium on Clinical Advances in Medicine. 1-298 pp. Price \$18.00 per clinic year, cloth binding; \$15.00 per clinic year, paper binding. W. B. Saunders Co., Philadelphia and London, 1951.

#### The Medical Clinics of North America.

March, 1951. Nationwide, Diseases of the Skin, McCann Symposium. 299-628 pp. Price \$18.00 per clinic year, cloth binding; \$15.00 per clinic year, paper binding. W. B. Saunders Co., Philadelphia and London, 1951.

#### The Surgical Clinics of North America.

April, 1951, New York, Orthopedic Surgery. 315-622 pp. Price \$18.00 per clinic year, cloth binding; \$15.00 per clinic year, paper binding. W. B. Saunders Co., Philadelphia and London, 1951.

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 305th regular meeting of the Hawaii County Medical Society was called to order by the president, **Dr. Leo Bernstein**, at 8 p.m., February 28, 1951, at the staff room of the Hilo Memorial Hospital. **Dr. John G. Lynn** of Honolulu and **Dr. John S. Horan** of Naalehu were present as guests.

**Dr. Sam R. Brown**, who recently returned to Hilo after a half-year tour of the mainland, was our speaker for the evening. He shared some of his valuable medical observations, which he made at various medical centers and at the 1950 Congress of the American College of Surgeons held in Boston. Of particular interest were the recent advances and trends in treatment of malignancies, intestinal adhesions, erythroblastosis fetalis, arthritis and respiratory allergies with ACTH, and one stage thoracoplasty.

Due to a lack of a quorum, no official business was transacted but opinions of the members were obtained on the more urgent matters.

A resolution to maintain the Veterans Administration in Hilo was read and discussed. After minor changes, **Dr. Phillips** moved that the revised resolution be approved and sent to the proper persons after approval by a few absent members to meet the quorum requirement. The motion carried. This action was necessary because time is short since the V. A. office in Hilo is closing on March 31, 1951. The revised resolution read as follows:

WHEREAS, the local Veterans Administration office has been performing excellent service to the veterans on the Island of Hawaii, and

WHEREAS, the veterans population on the Island of Hawaii consists of about 740 World War I veterans and about 5,400 World War II veterans, and

WHEREAS, the distance and transportation cost between Hawaii and Oahu are greater due to the jurisdiction being islands and not contiguous land areas, and

WHEREAS, there is no veteran hospital on this island but private physicians providing medical care of veterans in contract hospitals; NOW, THEREFORE,

BE IT RESOLVED, That the Hawaii County Medical Society does hereby go on record urging that the Veterans Administration office on the Island of Hawaii be maintained in order to continue to provide the excellent medical and other services peculiar to veterans without undue delay; and

BE IT FURTHER RESOLVED, That a copy of this resolution be forwarded to the Veterans Administration in Washington, D. C., and the Delegate to Congress from the Territory of Hawaii and that said Delegate be respectfully requested to use his office to attain this objective.

The president introduced **Dr. John G. Lynn** of Honolulu to the society members. Dr. Lynn made a few remarks on the necessity of the services of a neuropsychiatrist on this island. He is of the opinion that the territory will be greatly benefitted financially if a neuropsychiatrist made a weekly visit here if a permanent one is not available at this time. Most of the members

present were in favor of having a neuropsychiatrist make a weekly visit until a permanent psychiatrist is obtained for this island.

A special meeting of the Hawaii County Medical Society was called to order by the president, **Dr. Leo Bernstein**, at 7:35 p.m., March 13, 1951, at the staff room of the Hilo Memorial Hospital. **Dr. T. Watanabe** of Honolulu was present as guest.

The meeting was called to discuss H. B. No. 169 and other health legislation pertaining to the County of Hawaii.

The 306th regular meeting (annual meeting) of the Hawaii County Medical Society was called to order by the president, **Dr. Leo Bernstein**, at 8:15 p.m., March 24, 1951, at the Hilo Country Club. **Dr. H. P. Allison** of Tacoma, Washington, was present as guest.

An annual golf tournament was held in the afternoon.

**Dr. Mizuire** announced, primarily for the benefit of the out-of-Hilo doctors, that the X-ray treatment machine at the Hilo Memorial Hospital is already in use and its services are available to all.

A letter from **Dr. Tomoguchi**, chairman of the Nominating Committee, was read. The following nominations were presented:

President.....	<b>Dr. T. David Woo</b>
Vice-president.....	<b>Dr. S. Kosamoto</b>
Secretary.....	<b>Dr. Francis Wong</b>
Treasurer.....	<b>Dr. Richard Hoto</b>
Censor.....	<b>Dr. Leo Bernstein</b>

Action: **Dr. Phillips** moved, seconded by **Dr. Hara-guchi**. It was moved and carried unanimously, that the nominations be closed and the secretary be instructed to cast a unanimous ballot.

The Nominating Committee felt that the Delegates and Alternate Delegates should be picked from the members who will be able to attend the Territorial Medical Convention in Honolulu in May, and so did not make any nominations for these positions. There was a short discussion as to who will attend.

**Dr. Woo** moved to appoint as Delegates, **Dr. Crawford** and **Dr. Loo**; and as Alternate Delegates, **Dr. Bernstein** and **Dr. Seymour**. This was seconded by **Dr. Yuen** and carried unanimously.

**Dr. Bernstein** thanked the members and the various committeemen for the splendid way that they have cooperated during his year as President. Then he turned the meeting over to the next president, **Dr. T. D. Woo**.

**Dr. Woo** accepted the Presidency. There being no further business, the rest of the evening was further turned over to **Dr. Henry Yuen**, of Entertainment Committee Chairman. Dr. Yuen first presented the prizes to the golfers who took part in the afternoon tournament. Various games of skill followed and fun was had by all. The business portion of the meeting ended at 9:30 p.m.

PETE T. OKUMOTO, M.D.  
Secretary



The 307th regular meeting of the Hawaii County Medical Society was called to order by the president, **Dr. T. David Woo**, at 7:15 p.m., April 5, 1951, at The Lanai with the following members present: **Drs. Bernstein, M. L. Chang, Crawford, Gaenge, Kasamoto, Leslie, Miyamoto, Mizuire, Neil, Okumoto, Oto, Phillips, Tomoguchi, Wong, and Woo.** **Drs. Henderson and Zavadsky** of Puu-maile Hospital were present as guests.

Election of members of the Disaster Council was held by secret ballot. The following members were elected:

**Dr. Leo Bernstein**  
**Dr. Walter Seymour**  
**Dr. Clarence Carter**  
**Dr. Howard Crawford**  
**Dr. S. Kasamoto**

The Chairman will be chosen by the members of the Council at a later date.

It was voted that the Society invite medical teams on two separate occasions to conduct the course on the "Medical Aspects of Atomic Explosion" and that the Society underwrite the traveling expenses of the men conducting the course and that the money used for this purpose should be reimbursed by the Territorial Legislature if money is appropriated through passage of the Defense Bill. After a short discussion this motion was unanimously carried.

A motion to amend Chapter II, Section 2 of the Constitution and By-Laws to read, "Quorum: Ten members shall constitute a quorum," was made and unanimously carried. Final action will be taken at the next regular meeting.

A resolution, drawn up by the Communicable Disease Control Committee regarding immunization of all persons, on a voluntary basis, against tetanus and typhoid-paratyphoid fevers and encouraging and publicizing laws of the Territory requiring basic immunization against smallpox, diphtheria, and typhoid-paratyphoid fevers, was discussed. It was voted unanimously that the Society endorse the resolution.

A resolution expressing the Society's deepest regret at the death of Dr. John Milford was read. Dr. Leo Bernstein moved, seconded by Dr. Crawford, that the resolution be adopted. The motion was carried unanimously.

#### RESOLUTION

**Whereas, Dr. John J. Milford, Jr., M.S., Ph.D., M.D., has worked untiringly to care for the ill in the Puna district for the past year; and**

**Whereas, he has been a worthy member of the Hawaii County Medical Society and the Hawaii Territorial Medical Association; now therefore be it**

**Resolved, That the members of the Hawaii County Medical Society do hereby express their deepest regret at his death; and be it further**

**Resolved, That a copy of this resolution be sent to Mrs. Milford, and entered into the minutes of this Society.**

There being no further business, the remainder of the evening was spent in hearing Dr. H. C. Hinshaw of Stanford University School of Medicine talk on

"Diagnostic Problems in Thoracic Diseases." His talk was very interesting and instructive. The business portion of the meeting ended at 7:50 p.m.

**FRANCIS F. C. WONG, M.D.**  
*Secretary*

#### HONOLULU COUNTY MEDICAL SOCIETY

The March meeting of the Society was held on March 2, 1951, at 7:30 p.m., in Mabel Smyth Auditorium, with **Dr. Samuel Yee** presiding and about 119 members and guests present.

**Dr. Waite** announced that **Dr. H. Corwin Hinshaw**, of Stanford University Medical School and formerly of the Mayo Clinic, will be in Hawaii from April 1 to 10 under the joint sponsorship of the Territorial Tuberculosis Association and the Territorial Medical Association. He will deliver a series of lectures for Honolulu doctors and nurses in the Mabel Smyth Auditorium on April 2, 3 and 4, at 4:30 p.m.

Change in rates of private duty nurses was read.

The Territorial Association's Health Education Committee has suggested the placing of pamphlet racks in doctors' offices. The Board of Governors of the Honolulu County Medical Society found nothing objectionable and any doctor interested in having one of these racks should call the Medical Society office. There will be no cost to the doctor. Pamphlets will be supplied by the TB Association, Heart Association, Cancer Society, Polio Foundation, etc., and the Woman's Auxiliary and the members of the Health Educators Council will keep the racks filled. Doctors should specify the pamphlets they want.

The president announced that the Polio Foundation fee schedule which was circularized with the last bulletin lists the fees the Foundation will pay towards the doctor's bill. They are not to be construed as being the fees to charge. The Foundation will decide whether or not the patient is indigent or medically indigent to qualify for aid from the Foundation.

**Dr. Arnold, Jr.**, Chairman of the Legislative Committee, reported that nothing controversial has come up so far but that all doctors interested are urged to attend the committee meetings which are held on Tuesday afternoons.

The question of whether or not cancer should be a legally reportable disease was brought up. The Legislative Committee had recommended that legislation should be passed to make cancer reportable, but at the last Board of Governors meeting it was discussed at considerable length and the members felt it unwise to recommend such legislation.

**Dr. Quisenberry**, Chairman of the Cancer Committee of the Territorial Medical Association, stated that this matter came about because it was one of Dr. George Pack's recommendations for the Territory. There is considerable value in the statistics compiled in Hawaii because of its racial groups. He also reported that in New York City where cancer has been reported since 1939, they found no dissatisfaction on the part of doctors or anyone involved in the program.

**Dr. Hartwell** strongly advised against such legislation. He stated that cancer is non-communicable and is confidential information for the patient, his doctor and the pathologist. To submit such information is a gross invasion of individual rights. **Dr. Lowrey** also expressed similar views against cancer legislation. **Dr. Kepner**



moved that the Society uphold the decision of the Board of Governors that cancer should not be a legally reportable disease. Motion was seconded and carried.

Meeting adjourned at 10 p.m. to refreshments in the lanai.

WM. M. WALSH, M.D.  
*Secretary*

The annual meeting of the Honolulu County Medical Society and Library was held on April 6, 1951, at 7:30 P.M., in Mabel Smyth Auditorium. **Dr. Samuel Yee** presided; about 75 members and guests were present.

A letter from **C. L. Wilbar, Jr., M.D.**, Territorial Officer in Charge of Health Aspects of Disaster Relief, regarding the Communicable Disease Control Committee's resolution on immunization was received and read. On motion duly made and seconded, the Society voted in favor of endorsing the resolution of the Communicable Disease Control Committee regarding immunization of all persons, on a voluntary basis, against tetanus and typhoid-paratyphoid fevers and encouraging and publicizing laws of the Territory requiring basic immunization against smallpox, diphtheria, and typhoid-paratyphoid fevers.

**Reports of Officers and Committee Chairmen:** The following reports were presented and accepted with the exception of the Preparedness Committee Report which was accepted as corrected.

- Secretary's Report—**Dr. Wm. M. Walsh**
- Treasurer and Budget Committee Report—**Dr. William S. Ito**
- Program Committee Report—**Dr. C. M. Burgess**
- Committee on Forms of Medical Practice—**Dr. C. E. Fank**
- Legislative Committee Report—**Dr. H. L. Arnold, Jr.**
- Fee Adjustment Committee Report—**Dr. R. T. West**
- Public Service Committee Report—**Dr. Richard C. Durant**
- Postgraduate Committee Report—**Dr. K. S. Tam**
- Grievance Committee Report—**Dr. Jahn M. Felix**
- HMSA Representatives' Report—**Dr. Lyle G. Phillips**
- Library Committee Report—**Dr. R. G. Hunter**
- Preparedness Committee Report—**Dr. R. B. Faus**
- Report of Library Board of Governors—**Dr. F. J. Halford**
- President's Address—**Dr. Samuel L. Yee**

All reports are on file in the Medical Society office. In the absence of **Dr. Ito**, Treasurer, the Secretary, **Dr. Walsh**, presented a gift check to **Miss Ann Fujitani**, our Executive Secretary, who has resigned as of April 30 and is leaving Honolulu for residence on the Mainland.

**Election of Officers:** **Dr. Edward F. Cushnie**, Chairman of the Nominating Committee, read the report of his committee and the president presented the names for the various offices. Adequate opportunity was given for nominations from the floor. On motion duly made and seconded, the secretary was instructed to cast a unanimous ballot for those positions for which there was no competition. Election was by written ballot with **Drs. Robert Faus** and **Douglas Bell** as tellers and with the following elected:

- Officers:**
  - President—**Dr. Jahn Wm. Devereux**
  - Vice-President—**Dr. Wm. M. Walsh**
  - Secretary—**Dr. William S. Ito**
  - Treasurer—**Dr. C. M. Burgess**
- Board of Governors** (for two years)
  - Dr. A. L. Vascantellas**
  - Dr. Isaac Kawasaki**
  - Dr. Richard Chun**
- Alternate Board of Governors** (for one year)
  - Dr. Wm. H. Stevens**
  - Dr. Thomas Chang**
  - Dr. F. D. Nance**
- Board of Censors** (for three years)
  - Dr. Rogers Lee Hill**
- Committee on Forms of Medical Practice** (for five years)
  - Dr. Samuel L. Yee**

- Fee Adjustment Committee** (for three years)
  - Dr. H. M. Patterson**
  - Dr. Clifford Kabayashi**
- Delegates to the Hawaii Territorial Medical Association** (for two years)
  - Dr. Robert Benson**
  - Dr. C. M. Burgess**
  - Dr. Edward F. Cushnie**
  - Dr. Samuel L. Yee**
  - Dr. Richard C. Durant**
  - Dr. Wm. M. Walsh**
- Alternate Delegates to the Hawaii Territorial Medical Association** (for two years)
  - Dr. Jahn Peyton**
  - Dr. Laurence M. Wiig**
  - Dr. Paul Liljestrand**
  - Dr. Barney Iwanaga**
  - Dr. Duke Cha Chay**
- Representatives to Hawaii Medical Service Association** (for two years)
  - Dr. R. T. West**
  - Dr. Richard C. Durant**
  - Dr. Jahn M. Felix**
- Library Board of Governors** (for two years)
  - Dr. Wm. M. Walsh**
  - Dr. F. D. Nance**
  - Dr. L. C. Beck**
  - Dr. H. L. Arnold, Jr.**
  - Dr. B. Allen Richardsan**
  - Dr. Lester Yee**
  - Dr. James Wang**
  - Dr. M. E. Berk**

**Dr. Durant** stated that **Dr. Y. C. Yang** had been appointed Ambassador from the Republic of Korea to the United States and moved that the secretary, on behalf of the Medical Society and the profession write a letter of congratulations. Motion was seconded and carried.

After a brief message from the new president, the meeting adjourned to refreshments in the lanai.  
**WILLIAM S. ITO, M.D.**  
*Secretary*

KAUAI COUNTY MEDICAL SOCIETY

The monthly meeting of the Kauai County Medical Society was called to order by **Dr. Goodhue** at 7:30 p.m., January 10, 1951, at Wilcox Memorial Hospital Library.

A letter of the Tuberculosis and Health Association of Kauai was read in which the County Medical Society was asked to share half of the expense of the visit of **Dr. Hinshaw** of Stanford. It was moved and seconded that the society support this move.

A letter from the Hawaii Visitors Bureau asking for the support of the society was read. It was moved that the society donate \$105.00 to the bureau to be collected from the members on an assessment basis.

The County Society then went on record as endorsing a program of government support for the Bureau of Nutrition.

A letter from **Dr. John Sanders** of Maui was read dealing with the Board of Health's Hansen Disease program. The consensus of opinion of the members was to postpone any action on this subject.

**Dr. Hill** on his presidential visit addressed the society in reference to supporting the AMA program. He also made brief comment on his book, "Burn Therapy." **Dr. Faus** then spoke on Problems of Defense and reported on HMSA financial standing. **Dr. Nishigaya** gave a report on the Delegates' Conference in Cleveland, Ohio, to the AMA Public Relations meeting.

The monthly meeting of the Kauai County Medical Society was called to order by **Dr. Fujii** at 7:30 p.m., February 21, 1951, at Wilcox Memorial Hospital Library. Members present were: **Drs. Wallis, Kemp, Kuhns, Cockett, Bieber, Ishii, Fujii, Masunaga, and Kuhlman**. Guests were **Dr. Kim** and Judge Stratton.

It was announced by Dr. Kemp that the following days were being considered as suitable for lectures on Atomic Medicine: March 31, April 1, or April 8. The consensus of opinion of the society was to accept the latter two dates. The next topic to be discussed was that the society go on record as endorsing a Humane Society for Kauai. This was agreed upon.

The meeting was adjourned at 8:45 p.m. following which Judge Stratton held a forum on the problem of federal income taxes.

The monthly meeting of the Kauai County Medical Society was called to order by **Dr. Fujii** on March 14, 1951 at 7:30 P.M. at the Wilcox Memorial Hospital Library.

It was decided to postpone the atomic lectures for three months, because of insufficient funds in the treasury. It was decided that the Medical Society would meet with Dr. Hinshaw on April 9 at a luncheon to be held at Kauai Inn at 12:30 P.M.

A communication from the CAP was read requesting free services on immunization for members of the CAP. It was suggested that a letter determining the number of members participating in this program and whether they will be on a salary basis be sent to Mr. Presnal.

The new officers for the Kauai County Medical Society as determined by secret ballot were: President, **K. Fujii**; Vice-President, **K. Kuhlman**; Secretary and Treasurer, **N. Steuerman**; Censor for three years, **W. W. Goodhue**; Delegate, **D. Kemp**; Alternate Delegate, **J. Kuhns**.

K. F. KUHLMAN, M.D.  
Secretary

### MAUI COUNTY MEDICAL SOCIETY

A special all day luncheon meeting of the Maui County Medical Society was held at the Puunene Athletic Club at 9 a.m. on February 25, 1951, with **Dr. Cole** presiding. There were 28 guests consisting of members from the Territorial Disaster Relief Agency from Honolulu, local dentists, nurses and county health officers, who participated in a course on Medical Aspects of Atomic Explosions. Chairman was **Dr. R. B. Faus** (Chairman of Governor's Disaster Advisory Committee).

- 1) Film—U. S. Army, "Atomic Medical Care," Part I.
- 2) Plan for Medical Mobilization in Event of Atomic Explosion—**Dr. C. L. Wilbar, Jr.**
- 3) Coordination in Atomic Medical Services—Panel discussion  
**Dr. F. J. Pinkerton**—Blood Services  
**Dr. R. K. C. Lee**—Hospitalization, Communicable Disease Control, Medical Supplies, Laboratory Services  
**Dr. Dorian Paskowitz**—Personnel, Training, Public Education  
**Dr. R. B. Lane**—Moderator
- 4) Film "Atomic Medical Cases, Japan—World War II"
- 5) Radiation Syndrome in Man—**Major James G. Wood, Jr., U.S.A.**
- 6) Treatment of Mechanical and Thermal Injuries—Panel  
**Drs. J. W. Cherry, J. E. Strobe, P. Gebauer, Lester Yee and R. B. Cloward**
- 7) Film—"Pattern for Survival." Cornell Film Company
- 8) Radiation Detection and Decontamination—**Mr. Bernard McMorrow**

The well-rounded program was enthusiastically received and a vote of thanks was extended by the society to Dr. Faus and the participating members.

**Dr. Cole** announced that the 1951 AMA dues of \$25 are now payable. The checks made payable to the Hawaii Territorial Medical Association should be transmitted through our secretary.

**Dr. Faus** reported that the 10% withheld for Physicians' Reserve from January to June, 1950, will be refunded in the near future. He also brought up the matter of the basic contract between HMSA and the medical society which is to replace the present contract.

A special breakfast meeting of the Maui County Medical Society was held at the Puunene Club House on March 18, 1951, at 8 a.m. with **Dr. Cole** presiding.

Guests were **Drs. Thomas Fujiwara, Harold Civin, and Theodore Lathrop**, and Mrs. Paula Wong.

**Dr. Fujiwara** spoke on cortisone and ACTH and their uses particularly in shock therapy of burns. He also described the blood dyscrasias and the various hematological manifestations in the blood forming organs.

**Dr. Civin** described the common laboratory tests and procedures and its clinical applications. He particularly stressed the three liver function tests—zinc sulfate turbidity test, alkaline phosphatase test and prothrombin time.

It was moved and seconded that **Dr. Fleming** meet with the blood bank committee to discuss the establishment of a policy and procedure for meeting obligations of recipients of blood services as provided by the Blood Bank of Hawaii.

The election of officers for 1951-1952 were postponed until the next meeting.

A special meeting of the Maui County Medical Society was held at the staff room of the Puunene Hospital on March 27, 1951 at 8 P.M. with **Dr. Cole** presiding. **Dr. Theodore Lathrop** was present by invitation.

#### Finances:

Cash in bank as of January 16, 1951 .....	\$956.08	
Receipt from AMA dues .....	25.00	
Expenditures—operational .....		\$249.50
Balance as of March 27, 1951 .....	\$731.58	
Outstanding debt—None		

**Dr. Cole** announced that there will possibly be a joint meeting of medical and dental society and some other groups at the Puunene Club House on April 8 with **Dr. H. C. Hinshaw** of San Francisco as guest speaker.

A letter from **Dr. C. L. Wilbar, Jr.**, President, Board of Health, dated February 21, 1951 reaffirming its policies and actions regarding the Hansen's disease control program was read.

**Annual Elections**—**Dr. Kanda**, Chairman of the Nominating Committee, submitted the following nominations:

President.....**Dr. E. T. Shimokawa**  
Vice President.....**Dr. J. A. Burden**  
Secretary-Treasurer.....**Dr. E. Kushi**

It was moved, seconded and voted that the nominations be closed and that the secretary cast a unanimous ballot for the above candidates. Passed unanimously.

**Dr. Burden** and **Dr. Kanda** were unanimously elected Delegates to the Territorial Medical Association meeting in Honolulu.

**Dr. St. Sure, Jr.**, Chairman of the Pathologist Committee, reported that his committee has narrowed down the selection to 5 well qualified pathologists. He added that further negotiations concerning financial details in particular are in order before final selection.

EDWARD T. SHIMOKAWA, M.D.  
Secretary

A special breakfast meeting of the Maui County Medical Society was held at the Puunene Club House at 8:00 A.M. on April 8, 1951 with President **Dr. Ed. Shimokawa** presiding.

Guests were Dr. Lathrop, Mr. T. S. Shinn, Mr. J. Walter Cameron, Mr. Malcolm Clower, and twenty-two nurses of the Maui County Nurses' Association.

The speaker was **Dr. H. C. Hinshaw**, clinical professor of medicine, Stanford Medical School. He was introduced by President Shimokawa and an interesting lecture on diagnostic problems in thoracic disease was presented. Using twenty-seven slides and case histories, Dr. Hinshaw discussed in detail a variety of problems in thoracic disease.

A. Y. WONG, M.D.  
*Secretary, pro tem.*

1 1 1

A regular meeting of the Maui County Medical Society was held at the Maui Grand Hotel at 6:30 P.M. on Tuesday, April 24, 1951, with President, **Dr. E. Shimokawa**, presiding.

Members present were: **Drs. Kanda, Sanders, Cole, Toney, Ohata, Shimokawa, Kashiwa, Burden, H. Kushi, Rockett, Underwood** and **Jim**.

**Drs. A. Y. Wong** and **E. Kushi** were in Honolulu.

**Dr. Cole** was appointed representative to the H.M.S.A.

A letter dated April 2, 1951, from **Dr. Charles L. Wilbar** was read to the members. It was unanimously approved by the Society to adopt the resolution as presented by the Territorial Disaster Relief Agency on immunization.

**Miss Nell McKeever** will speak to a joint meeting of the Maui Medical and Dental Society sometime in June. She is the Consultant, Public Health Adult Education, Bureau of Chronic Diseases. **Dr. Lathrop** is to make all arrangements to have her appear on Maui.

It was duly moved and seconded that meetings with **Dr. Traut** and **Dr. Eastman** be dinner meetings. Members were told that the dates were May 9, 1951, and May

16, 1951. **Dr. Traut** will arrive on May 9, 1951. **Dr. Al Burden** is responsible for all arrangements for these two special events.

Communication of April 19, 1951, was read by **Dr. Edmund Tompkins**, relating to Bureau of Crippled Children and Bureau of Maternal & Child Health. **Dr. Tompkins** asked the Society for criticisms or suggestions to take to the meeting of May 3, 1951. Most of the members had nothing to say so left it to **Dr. Tompkins** to use his judgment and discretion at the meeting.

Committee appointments for 1951-1952 follow:

*Medical Disaster Committee:* **Dr. Underwood** (Chairman), **Drs. Izumi, Ferkony, Toney, Burden** and **Mor**.

*Medical Economics and Public Relations Council:* **Dr. Hoywood** (Chairman), **Drs. Tofukuji, Cole, St. Sure, Jr., Rockett** and **Jim**.

*Program Committee:* **Dr. McArthur** (Chairman), **Drs. Patterson** and **Izumi**.

*First Aid for County Fair:* **Dr. Konda**.

*First Aid for Fourth of July:* **Dr. Koshiwo**.

*Publicity:* **Dr. Edward Kushi**.

*Representative to Maui Chapter, Hawaii Cancer Society:* **Dr. Ferkony**.

*Consultants to Cancer Committee:* **Dr. Ferkony** (Chairman), **Drs. Ohata** and **Haywood**.

*Blood Bank:* **Dr. A. Y. Wang** (Chairman), **Drs. St. Sure, Jr., Jim, Fleming, Knox** and **S. K. Wong**.

*Advisory Group to Legislature Holdover Committee on Hospitals, Medical Care, Health and Welfare:* **Dr. Izumi** (Chairman), **Drs. Sanders, Tompkins, Toney, Wilkinson, Reppun, St. Sure, Jr., Edward Kushi, A. Y. Wang** (Dr. S. Miura, representative from dental society, and Mrs. Elizabeth McCall from nurses' association).

*Nominating Committee:* **Dr. Cole** (Chairman), **Drs. Sanders** and **Kanda**.

*Grievance Committee:* **Dr. Fleming** (Chairman), **Drs. Ohata** and **H. Kushi**.

*Annual Picnic:* **Dr. Sanders** and **Dr. Fleming**.

*Advisors to Women's Auxiliary:* **Dr. Potterson** and **Dr. H. Kushi**.

*Golf Committee:* **Dr. H. Kushi** (Chairman), **Drs. McArthur** and **Rockett**.

*Committee for Selection of Pathologist:* **Dr. St. Sure, Jr.** (Chairman), **Drs. Toney, Tompkins** and **A. Y. Wong**.

*Advisory Committee to Procurement and Assignment Committee:* **Dr. Burden** (Chairman), **Drs. McArthur, Tompkins, Cole** and **Underwood**.

HAROLD KUSHI, M.D., and  
SEIYA OHATA, M.D.  
*Secretaries, pro tem.*



# NOTES AND NEWS

## PERSONALS

A signal honor to the local medical profession came with the recent appointment of one of our members, **Dr. Y. C. Yang**, of Honolulu, to become the Ambassador from Korea to the United States. Dr. Yang has been a practicing physician in Honolulu since 1923. He was born in Korea and has been a good friend of President Syngman Rhee, of Korea, for many years. On a recent trip to Korea, he was given this high honor and will take his duties in Washington, D. C., in the near future. THE JOURNAL congratulates Dr. Yang and wishes him much success.

**Dr. and Mrs. A. L. Vasconcellos** have recently returned from a trip to the mainland. Dr. Vasconcellos went as an officer and delegate to the annual convention of the American Academy of General Practice in San Francisco. He has just been elected President of the Territorial Academy of General Practice.

**Dr. Martin H. Lichter**, of Honolulu, has returned from a brief trip to the mainland, where he attended the annual convention of the American Academy of General Practice and also a postgraduate course at the College of Medical Evangelists in Los Angeles. He visited his son, Dr. Rowlin Lichter, who recently completed his internship at the Cook County Hospital in Chicago and has been commissioned in the United States Army Air Force. Dr. Lichter has just been elected Treasurer of the Territorial Academy of General Practice.

The Kuakini Hospital has added two new internes to their interne staff: **Dr. Takeshi Hagimoto**, of Kobe, Japan, who is a graduate of Osaka Medical College, 1949, and **Dr. Takashi Tanimukai**, of Nishinomiya, Hiogo Prefecture, Japan, who is a graduate of Kiyoto Prefecture Medical College, 1949.

**Dr. James Cherry**, of Honolulu, has begun a year's fellowship in general surgery at the Lahey Clinic in Boston. Mrs. Cherry and their two children accompanied him.

**Dr. and Mrs. Richard Durant** are the proud parents of their fifth child, a son, born at the Kapiolani Hospital on March 19. The Durants now have three sons and two daughters.

**Dr. John G. Lynn**, Chief of the Bureau of Mental Hygiene these last three years, entered private practice in Honolulu in May.

Dr. Lynn was graduated from St. Johns College and the University of Maryland School of Medicine. In 1934 he became the resident Psychiatrist at McClean Hospital, Waverley, Massachusetts, where he stayed for three years. From there he went to the Neurological Institute in New York as Assistant Resident Neurologist. During this time, he also had his psychoanalytic training-analysis with Dr. Karen Horney, and took courses in the Rorschach method from Dr. Bruno Klopfer. He was made chief psychiatrist in charge of the Psychiatric Institute of Grasslands Hospital in Valhalla, New York.

In 1945 he became Chief Psychiatrist in charge of Psychiatric Clinics on the Islands of Maui, Kauai, Hawaii, and Oahu under the Bureau of Mental Hygiene.

Among the many professional jobs he has held, Dr. Lynn was Research Associate in Neurology at the College of Physicians and Surgeons, Columbia University, New York, and Associate Director of a Head Injury project in the Department of Neurology at Columbia.

Dr. Lynn is a member of the American Psychopathological Association, the American Society for Research in Psycho-Somatics, the American Psychological Association, the American Psychiatric Association, American Public Health Association and the Honolulu County Medical Society.

## Need an Office?

Offices in Young Building, completely equipped for general practitioner, for sale or rent. For information phone 5-6893.

## Hawaii

### Matter-o-Money

**Dr. Hoei Higa** of Hilo is no longer a single man, folks. He upped and did it on March 17, 1951. The lucky girl was Miss Natalie Fumie Maeda. Congratulations are in order.

### Miscellaneous

**Dr. Corwin Hinshaw** of Stanford University School of Medicine and formerly of the Mayo Clinic, was our guest speaker at the April 5 regular meeting of the Hawaii County Medical Society. He spoke on "Diagnostic problems in thoracic diseases."

**Dr. H. P. Allison** of Tacoma, Washington, was a visitor in Hilo in March. He attended the Society's annual meeting on March 24, 1951.

**Dr. William Bergin** attended the San Francisco Convention of the American Academy of General Practice in March.

## NEWS

### Hawaii Tuberculosis and Health Association

The Hawaii Tuberculosis and Health Association in conjunction with the Hawaii Territorial Medical Society jointly sponsored a series of very instructive lectures by a noted tuberculosis authority, **Dr. H. Corwin Hinshaw**, of San Francisco, California, during the month of April. Dr. Hinshaw is Clinical Professor of Medicine at the Stanford University School of Medicine and he was formerly a head of a section in medicine at the Mayo Clinic, Rochester, Minnesota. The lectures were presented at the Mabel Smyth Memorial Building, Honolulu, on "Diagnostic Problems in Thoracic Disease," "Antimicrobial Treatment of Tuberculosis; Pulmonary and Extrapulmonary," and "Cancer of the Lung." The first lecture was repeated to the Maui, Kauai, and Hawaii Medical Societies. In addition to the foregoing he gave a public lecture on the "Changing Concepts in Tuberculosis; Treatment, Diagnosis, and Control."

### John James Milford, Jr., M.S., Ph.D., M.D. 1914-1951

Dr. Milford died suddenly at his home in Olaa, Hawaii, March 25, 1951. Born in Birmingham, Alabama, November 6, 1914, he received his elementary education in the public schools of Huntsville, Alabama, graduating from the Huntsville High School in June, 1930. His training and degrees included: Bachelor of Science from Howard College, Birmingham, Alabama, June, 1945; Graduate School at New York University, 1935-1940; Assistant in Embryology, Woods Hole, Massachusetts, 1937-1940; Master of Science in Parasitology, New York University, 1937; Doctor of Philosophy in Vertebrate Morphology and Embryology, 1940; M.D. from Yale University School of Medicine, December, 1943; Research Assistant to Prof. Francisco Duran-Reynals, Yale University, Dept. of Pathology and Bacteriology, 1941-1943; Internship at Massachusetts General Hospital, 1944; war service in the Pacific area 1944-1946 as Ship Surgeon on destroyer, engaged in underwater demolition work in the Philippines, Okinawa and Japan area; Instructor in Physiology, University of Washington School of Medicine, 1947-1948.

Dr. Milford came to Hawaii in August, 1948, and served as an assistant in general practice to Dr. Edgar S. Childs, in Honolulu, until August, 1949, when he went to the Olaa Plantation as an assistant to Dr. Donald Depp and some six months later took over as head plantation physician until his death in March, 1951.

Dr. Milford was active in research work throughout the whole span of his formal education and participated in a number of projects and was co-researcher and co-author of numerous publications. Dr. Milford was elected to Sigma Xi, scholastic society, while in graduate school, and to A.O.A. in Medical school. He is survived by his wife, Anna Snyder Milford, a graduate of the Yale School of Nursing, 1938, and two sons.

To those who knew him well, Dr. Milford was a man of solid intellectual attainments and a true friend; he practiced medicine seriously, scientifically and humanly and won the admiration and affection of his patients both in Honolulu and in the Puna district of Hawaii. His untimely death was a shock to both his friends and patients and will be felt especially by those in his district on Hawaii where he so conscientiously treated the sick for the past eighteen months.

EDGAR S. CHILDS, M.D.

### Honolulu Surgical Society

Dr. Roger Anderson, widely known orthopedic surgeon, of Seattle, Washington, delivered an interesting presentation on "Recent Advances in Orthopedic Surgery" at the meeting of this society in March. Dr. W. H. Bernhoff, of Buffalo, New York, was unable to reach Honolulu in time to give his paper on "Polyps of the Colon and Rectum," but he spoke on proctologic subjects at The Queen's Hospital Staff Meeting, a few days later.

### General Practitioners Affiliate

On April 2, 1951 the American Academy of General Practice following their third annual convention in San Francisco presented a charter to the Territorial Academy of General Practice. This marked the highlight of a post convention tour to Hawaii of over 50 mainland doctors and their wives.

Charter members and officers of the new Territorial Academy of General Practice include **Drs. A. Leslie Vasconcellos**, President; **Samuel R. Wallis**, 1st Vice President; **John W. Devereux**, Secretary; **Martin H. Lichter**, Treasurer; **Maxwell H. Boyd**, Executive Secretary; **William Walsh**, Vice President for Oahu; **Walter M. Ozawa**, Director for Oahu; **Archie Orenstein**, Vice President for Hawaii; **Walter J. Seymour**, Director for Hawaii; **Ransom J. McArthur**, Vice President and Director for Maui; and **William W. Goodhue**, Director for Kauai.

Among the distinguished visitors present at the post convention program were **Dr. and Mrs. Stanley R. Truman** of Oakland, California, one of the original organizers and the immediate past president of the A.A.G.P.; **Dr. William Beuchler** of Syracuse, New York, 1st President of the New York State Chapter and a Director of A.A.G.P. representing **Dr. J. P. Sanders**, President; and **Mr. and Mrs. Mac F. Cahal**, Executive Secretary of the A.A.G.P.

The scientific program which received considerable favorable comment was as follows:

**Dr. Marquis E. Stevens**—*Some Practical Aspects of Psychosomatic Medicine*

**Dr. E. F. Cushnie**—*N.S.D. (Normal Spontaneous Delivery)*

**Dr. William Walsh**—*ACTH in the Stevens-Johnson Syndrome*

**Dr. Nils P. Larsen**—*The Art of Medicine in Ancient Hawaii*

**Dr. Edwin Chung-Hoon**—*The Mimicry of Medicine*

The evening program consisted of cocktails, a nine-course Chinese dinner, Hawaiian entertainment, and presentation of the Charter following which all enjoyed dancing for the remainder of the evening. Two hundred and twenty attended the affair. **Dr. William Walsh** was Master of Ceremonies.

Thanks and appreciation for the success of the day's program go to **Dr. J. W. Devereux**, General Chairman; **Dr. J. Felix**, Chairman, Program Committee; **Drs. D. Depp**, **William Ito**, **R. Bailey** and **F. Chang** of the Banquet Committee and **Dr. and Mrs. T. Fujiwara** of the Host-Hostess Committee. Other members of the Auxiliary who contributed so much to its huge success included **Mrs. Toru Nishigaya**, Oriental Tea Party; **Mrs. Robert Katsuki**, Chairman Hostess at the Royal, and **Mrs. Louis Gaspar** in charge of decorations.

### International Congress of Physical Medicine 1952

The Congress will be held in London from July 14 to 19, 1952.

In accordance with the regulations of the International Federation of Physical Medicine, the meetings of the Congress will be reserved for matters dealing with the clinical, remedial, prophylactic and educational aspects of Physical Medicine and with the diagnostic and therapeutic methods employed in Physical Medicine and Rehabilitation.

This is a preliminary notice and full details will be given later. Applications for the Provisional Programme should be addressed to the Honorary Secretary, International Congress of Physical Medicine (1952) 45, Lincoln's Inn Fields, London, W.C.2.

### Plastic Surgery Awards—1951

The Foundation of the American Society of Plastic and Reconstructive Surgery offers Junior and Senior Awards for original contributions in Plastic Surgery.

*Junior Award:* Two Scholarships in Plastic Surgery of six and three months respectively.

The contest is open to plastic surgeons in the specialty not longer than five years.

*Senior Award:* For the best essay on "Mass Treatment of Burns in Atomic Warfare."

The winning essays will appear on the program of the forthcoming annual meeting of the American Society of Plastic and Reconstructive Surgery to be held at Colorado Springs, Colorado, October 31-November 2, 1951.

All entries must be received by the Chairman not later than August 15, 1951.

For full particulars write to:

The Award Committee  
c/o Jacques W. Maliniac, M.D.  
11 East 68th Street  
New York 21, N. Y.

### Department of Health, Office of Health Education

"Taking Care of Diabetes," a complete kit of eleven filmstrips with transcriptions, pamphlets and wall charts, is available on loan from the Health Education Office of the Territorial Department of Health.

The kit of audio-visual aids was especially designed for group teaching of diabetic patients in the physician's office or hospital. It is also suitable for use in nursing education and in college courses in diet therapy and nutrition. It was produced by the Public Health Service Diabetes Branch, the American Dietetic Association, and the American Diabetes Association.

Physicians may arrange to use the kit through **Dr. Walter B. Quisenberry**, Phone 71997. Nursing, dietetic, and nutrition instructors may call Mrs. Marjorie Abel, Phone 50511. Their mailing address is P. O. Box 3378, Honolulu.

### Honolulu Obstetrical and Gynecological Society

Two distinguished mainland professors delivered addresses and participated in round table discussions at the two meetings of this society in March. The first meeting was on "Functional Uterine Bleeding" by **Dr. Arthur K. Koff**, Chairman of the Department of Obstetrics and Gynecology, Michael Reese Hospital, Chicago, Illinois. The other speaker was **Dr. Clyde Geiger**, Professor of Obstetrics and Gynecology, Stritch School of Medicine and Loyola University, Chicago, Illinois. He spoke on "Treatment of Carcinoma of the Corpus and Cervix Uteri."

### Polio Treatment Courses

The following short courses in the treatment of poliomyelitis patients for physicians, nurses, and physical therapists have been scheduled on the West Coast for the following dates:

**ORTHOPAEDIC HOSPITAL, LOS ANGELES, CALIFORNIA.** Courses for physicians, October 22-25. For nurses, October 22-26. For physical therapists, October 22-26.

**UNIVERSITY OF COLORADO MEDICAL CENTER, DENVER, COLORADO.** Courses for physicians, December 13-15, post-graduate course on poliomyelitis in conjunction with other pediatric problems, open to all interested physicians such as general practitioners, orthopedists, public health officials, as well as pediatricians. For nurses and physical therapists, June 18-July 6.

The Honolulu Chapter of the National Foundation for Infantile Paralysis will be pleased to assist any of the above professional personnel who may be on the mainland at the time these courses are conducted and who wish to take advantage of this training. Financial aid will be provided to cover all expenses connected with the course with the exception of transportation.

Additional courses are offered on the East Coast. For detailed information contact the Honolulu Chapter office, 810 North Vineyard Street. Telephone 8-3945.



# Not only enough bulk ...but plenty of water



## ...with **METAMUCIL®**

To assure the patient of the necessary quantity of liquid and natural mucilloid expedient to the promotion of peristaltic movement, Metamucil is to be taken with a full glass of cool liquid and may be followed by another glass of liquid if indicated.

Metamucil, mixed with water, produces:

- • • • a bland mass which is intimately miscible with the intestinal contents and is extended evenly throughout the digestive tract
- • • • gentle stimulation of the bowel wall, initiating normal reflex peristalsis
- • • • medium stools—not hard, not soft
- • • • no irritation, straining, impaction and
- • • • no interference with digestion or absorption of oil-soluble vitamins.

**METAMUCIL®** is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. G. D. Searle & Co., Chicago 80, Illinois.

# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE



# SAFARI

AFRICA—Land of Big Game and Primitive Peoples . . . sunswept grasslands . . . dark, adventurous jungles! Let us help you plan a SAFARI thru the depths of Africa!

Wherever you go—by land, sea, or air—INTERNATIONAL TRAVEL SERVICE will make arrangements for your trip—at no extra cost to you! We arrange transportation on all carriers, make hotel reservations, and relieve you of details to make your trip completely carefree.



*Ask about our personally conducted tours.*



## INTERNATIONAL Travel Service

King at Bethel Streets Honolulu Ph: 59517-67558  
 Waikiki Branch Outrigger Arcade Between  
 Royal and Moano Hotels Ph: 93344-991514  
 Hilo Hilo Hotel Building Ph. 5328



### New 2-Way Aid in ACNE

Now hide and treat acne blemishes simultaneously with new AR-EX R.M.S. Lotion. Complexion tinted. Contains resorcinol monoacetate and sulphur in gentle AR-EX Foundation Lotion. Non-astringent.



Send for Free Sample.

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

## BULLETIN COMMITTEE

ANGELA M. CARLUCCI, *Editor*, Leahi Hospital, Honolulu  
LAURA DRAPER, *Nursing Information Committee*, Board of Health, Honolulu  
LEAH BIGELOW, *Nursing Information Committee*, St. Francis Hospital, Honolulu  
MABELCLAIRE NORMAN, *Executive Secretary*, Honolulu  
ALISON MCBRIDE, *Territorial Association Secretary*, Honolulu

### *Secretaries*

BESS HAMMER, Hawaii  
VIRGINIA RAUTENBERG, Honolulu  
PAULINE JOHNSON, Kauai  
LAURA WONG, Maui

### *Publicity Chairmen*

GRACE LUSBY, Hawaii  
HELEN GAGE, Kauai  
MICHIE KAMITAKI, Maui

## CONDENSED REPORT OF THE NURSING STUDY COMMITTEE\*

ALISON MacBRIDE, R.N.

The review of the current nursing situation in the Territory indicates the following needs:

In hospitals without schools of nursing, approximately 50% of the nursing care is being given by practical nurses who obtained licenses on the basis of experience and without any, or with only limited, on-the-job preparation for the functions they are asked to assume. Few graduates of the program for practical nurses are as yet employed in hospital nursing service outside Oahu.

The staff nurses in these hospitals are graduate nurses with little preparation for the responsibility of directing a large number of inadequately prepared practical nurses in patient care.

The positions for administration of nursing service are filled largely by graduates of mainland schools. This is because graduates of local schools have not had the opportunities to receive the preparation and experience to qualify them to compete with mainland graduates for these positions.

Where graduates of local schools have spent 2½ to 3 years in preparation for teaching and supervisory positions, either in hospitals or public health, opportunities for employment have been open to them. Such preparation has, in general, been obtained by completing the bachelor's degree requirements at the University of Hawaii in part-time study while working, and one year in master's level study on the mainland. The total number of positions available now or in the future for teaching in schools of nursing, supervision and administration in hospital and public health nursing is too limited to warrant the development of preparation for these fields in the University of Hawaii.

\* Condensed from Preliminary Report of Miss Ruth Gillan, R.N., USPHS.

Graduates of local schools of nursing are at present receiving an educational program that compares very favorably with that given in similar schools on the mainland. They are, however, at present not qualified by this preparation for positions in public health or for the management of large numbers of practical nurses in hospital nursing service. None of the students at the present time have an opportunity to experience the satisfactions that result from working in the community hospital organized as a health agency in the small community, nor do they have the opportunity of experience in caring for patients in their homes.

There are at present 858 professional nurses employed in hospitals. Of these 225 are in teaching, administrative work or staff level positions in the three hospitals with schools of nursing. Therefore the existing hospital schools, or graduates from the mainland, are supplying nurses for 638 (73%) of the nursing service positions in hospitals in the Territory.

These inadequacies in the present nursing education system and in nursing service could be overcome if:

1. Nursing education programs in the Territory were so organized that for the next five years the Territory plans to prepare ⅓ of its new nurse supply by graduates of the practical nurse program; ⅓ by graduates from diploma programs leading to the R.N. on successfully passing the examination for a license; and ⅓ from a basic program organized at the University of Hawaii. In two years these ratios should be reviewed and revised in terms of changing nursing needs.
2. The Territory would establish a program in nursing, preparing nurses for staff level positions in hospitals and public health and conferring a degree of Bachelor in Nursing at the University of Hawaii. This program should include an opportunity to work in a rural hospital as well as field experience in public health under supervision.
3. Provision would be made for scholarship assistance and reciprocal agreements to allow a sufficient number of graduates to secure preparation on the mainland for advanced level positions such as teaching in schools of nursing, supervision and adminis-



tration in hospital and public health nursing service. Perhaps 10 such scholarships annually would be sufficient at the present time. It must be pointed out that preparation for these positions is becoming increasingly difficult to obtain *except on a master's level*. Unless sufficient candidates with a bachelor's degree are available for preparation in these fields from graduates of schools within the Territory, in a few years these positions will have to be filled entirely with personnel from the mainland. It is the consensus of the advisory, executive and subcommittees to the study that mainland contacts are essential to prevent insular containment in nursing in the Territory. They believe that the Islands should prepare approximately 75% of their total professional nurse supply, that some supervisory, teaching and administrative positions should be filled with mainland graduates. They also believe that graduates of local schools, when prepared for advanced positions, have a great deal to contribute. Such graduates understand the problems and advantages that accrue from cultural mores contributed by a population of varying origins. Local nurses, well prepared by advanced nursing education programs on the mainland, will contribute greatly to the hospital and public health nursing services that all citizens of the Territory need.

4. More graduates of the practical nurse program should be employed in hospitals on islands other than Oahu. At present 50% of each class admitted come from other islands. Plans are being developed to provide practice for these students on the islands of their residence. It has been demonstrated many times that practical nurses with hospital experience obtain employment more easily. These students are able to demonstrate to hospital and nursing administration that the well trained practical nurse working under professional supervision can contribute a great deal to nursing service. The *prepared* practical nurse used wisely in a well organized nursing service can help improve patient care. As practical nurse students receive experience in hospitals with untrained or on-the-job trained licensed practical nurses, they have stimulated an interest in the waived practical nurse to become eligible for license by examination. The Vocational Education Division of the Department of Public Instruction is anxious to develop the extension type of courses wherever there is a demand for them. If at least 10 people desire such a course, the Department, if assured that the students will be able to attend the classes, will give a qualified nurse from the area sufficient preparation to teach such programs. The Department will pay her salary and provide the supervision needed. The Territorial Hospital Association, County Nurses Association and the Practical Nurses Association should take the initiative in developing the demand for these courses and submit requests for them to the Vocational Education Division of the Department of Public Instruction.

#### RECOMMENDATIONS RELATING TO SPECIFIC AREAS OF NURSING SERVICE AND NURSING EDUCATION

##### I. Hospital Nursing Service:

1. Each hospital should provide professional nurse supervision for 24-hour coverage.
2. Hospitals without schools of nursing should provide a bedside nursing staff in a ratio of one professional to one practical nurse and effort should be made to up-grade the quality of nursing practice by the waived licensed practical nurses.\*

\* Further study of the needs of patients for nursing care may indicate a more desirable ratio as more trained practical nurses become available.

- a. As positions for practical nurses become vacant, they should be filled only with graduates of the practical nurse programs. It is the immediate objective to discontinue the granting of temporary licenses. These should be granted only when a licensed practical nurse is not available, and upon passing a special examination.
- b. The Hospital Association and District Nursing Association should take positive steps to encourage the practical nurses licensed by waiver to become licensed by examination. This could be done through completing the program of 64 hours of theory outlined by the National Association for Practical Nurse Education. There should be a minimum of 36 hours of supervised practice added to give these nurses the assurance that comes from successful practice under professional guidance. This program has been found to supplement the experience gained through practice of the waived licensed nurses.
- c. The two year on-the-job extension program as planned by the Vocational Education Division of the Department of Public Instruction should be given this group to enable them to qualify for license by examination.
3. Opportunities and scholarship assistance from Territorial and other funds should be available to enable graduates of local schools of nursing to become prepared to function in positions as supervisors and directors in hospital nursing service. These should also provide for preparation in the clinical specialties including anesthesia.
4. A nurse, well qualified for hospital nursing service administration, should be appointed as a consultant to the Territorial Department of Health. She should study the organization, administration and functioning of hospital nursing service, conducting institutes, staff education programs and other methods of improving nursing service should be her major functions. Private practice nurses should be included in these.

##### II. Industrial Nursing Service:

Efforts should be directed toward—

1. Developing a greater awareness on the part of employers of the contribution of the industrial nurse to plant health and improved productivity of the workers.
2. Establishing qualifications and standards for nurse employment that will enable management to secure the best possible service for the money expended.
3. Developing workshops, institutes and other means of increasing the effectiveness of the nurses now employed.
4. Requesting that the University of Hawaii consider whether or not some aspects of industrial nursing could be included in programs now offered or to be developed.
5. Encouraging establishment with a small number of employees to develop a central or cooperative medical and nursing program.

### III. *School Nursing Service:*

1. In the Intermediate and Secondary Schools, when appointment to the position of health coordinator is made on a temporary permit, preference should be given to the nurse with public health preparation and experience rather than to the teacher with no special preparation for health teaching.
2. A pediatric nurse consultant should be employed on the staff of the Territorial Department of Health, who will have a good background in school nursing in order to give supervision and guidance in this area.
3. Nursing service to schools dependent upon the generalized public health nurse should be made more nearly adequate by providing a minimum ratio of one nurse to 3,000 population in each county. This minimum ratio will need to be carefully reviewed in the event of any expansion in the present school health program.

### IV. *Public Health Nursing Service:*

1. A demonstration area should be developed to provide bedside nursing service in homes by public health nurses.
2. Scholarship funds for the preparation of supervisory and consultant personnel should be obtained.
3. The ratio of nurses to population needs to be carefully reviewed in relation to new programs in public health. Where heavy loads are added to the generalized programs because of population concentrations or geographic distances the ratio of 1:5,000 is inadequate.
4. The Civil Service classifications as now set up should be audited to determine what revision of job descriptions, classification, and ratings is needed.

### V. *Private Practice Nursing:*

The Nursing Service Bureau estimates that an additional 25 private practice nurses would be adequate for current needs. There are no criteria for estimating future needs in this field of practice.

The greatest need in this field is not for more nurses but for opportunities for private practice nurses to be kept up to date on current nursing and medical practice.

### VI. *Nursing Service in Doctors' Offices:*

Thirty doctors stated they would employ registered nurses in their offices if available. The future need under current conditions is therefore not very great in this field of practice. However, if a large number of private physicians are called to military service, there may be a marked change in the need for qualified professional nurses to extend the services of civilian physicians to a larger segment of the population.

### VII. *Recommendations Relating to Nursing Education:*

1. A college of nursing should be established at the University to prepare nurses to practice at the staff level in public health and hospital nursing service.
2. Present hospital schools should continue admission to their programs for at least two years. At the end of this period it should be determined to what extent each of the schools should prepare professional nurses to meet the needs of the Territory.

3. The University of Hawaii should continue the programs for graduate nurses now offered as long as there is a need for them.
4. Scholarships should be made available from Territorial or other funds to allow nurses now to become prepared to meet the needs of the Territory for instructors in schools of nursing, clinical specialists, and in other areas of nursing.
5. The Practical Nurse Training Course in Honolulu should continue to provide the teaching for the year program, that student practice be planned in hospitals on other islands for residents of these islands.
6. Extension courses under the practical nurse program should be administered by the Practical Nurse Training Course for the up-grading of the present supply of practical nurses licensed by waiver.
7. The Legislature should request the Governor to appoint a Commission on Nursing Services and Nursing Education whose membership will be predominantly made up of nurses qualified in administration of nursing education. The Commission would review the survey recommendations and determine how they may be implemented, and would study the nursing situation as seems indicated in the future.

### LEGISLATION NEEDED TO IMPLEMENT STUDY RECOMMENDATIONS\*

- I. Enabling the establishment of a college of nursing at the University of Hawaii, with a Dean of Nursing. An appropriation for the administration of this college. The construction of a building for offices and classrooms and an appropriation for such construction.
- II. A scholarship fund for the preparation of local nurses in mainland universities for supervisory, instructional and administrative positions in the Territory.
- III. The appointment by the Governor of a Commission on Nursing Services and Nursing Education to implement recommendations of this study, and to study the nursing situation as needed in the future.
- IV. The position of hospital nursing consultant in the Territorial Department of Health, under the proposed Division of Hospitals and Medical Care, or under the Bureau of Public Health Nursing.

### MEMBERS OF THE NURSING STUDY COMMITTEE

#### Officers:

<i>Chairman</i> .....	Miss Alison MacBride
<i>Co-Chairman</i> .....	Mrs. Allan J. McGuire
<i>Secretary</i> .....	Mrs. Rosie Kim Chang
<i>Treasurer</i> .....	Mrs. Arlene Thompson

#### Executive Committee:

Miss Alison MacBride	Mrs. Allan J. McGuire
Mrs. Rosie Kim Chang	Mrs. Arlene Thompson
Sister Mary Jolenta	Miss Mary V. Cheek
Mrs. Elizabeth Koenig	Miss Virginia Jones
Mrs. Marjorie Elliott	Mrs. Myrtle Schattenburg
Dr. Richard K. C. Lee	

\* Appropriate bills covering the first two legislative needs, and a joint resolution to create the Commission, were introduced in the Twenty-sixth Legislature.



**Advisory Committee:**

Miss Alison MacBride  
Mrs. Rosie Kim Chang  
Sister Mary Jolenta  
Mrs. Elizabeth Koenig  
Mrs. Marjorie Elliott  
Dr. Richard K. C. Lee  
Miss Esther Conroy  
Dr. Arthur L. Dean  
Professor Wilfred Holmes  
Mrs. Guy N. Rothwell  
Mrs. Allan J. McGuire  
Mrs. Arlene Thompson  
Miss Mary V. Cheek  
Miss Virginia Jones

Mrs. Myrtle Schattenburg  
Mrs. Virginia Ahrendt  
Mrs. Garner Anthony  
Dr. John W. Devereux  
Mrs. Hatsumi Ishikawa  
Mr. W. Tate Robinson  
Sister Marie Therese  
Miss Moira Wilson  
Mrs. Helen Gage  
Mrs. Lydia Dupont  
Sister Mary Albert  
Mrs. Elizabeth McCall  
Miss Thelma Hensley

**Technical Committees:****Hospital Nurses:**

Sister Mary Albert, *Chairman*  
Miss Frances Alexander  
Mrs. Patience Martelon  
Mrs. Guy Rothwell

**Educational Program:**

Miss Mary V. Cheek,  
*Chairman*  
Miss Virginia Jones  
Mrs. Myrtle Schattenburg

**Private Practice:**

Mrs. Illa Storme, *Chairman*  
Mrs. Ine Higa  
Mrs. Esther Higuchi  
Miss Lillian Jonsrud  
Mrs. Arlene Thompson

**School and Public Health Nurses:**

Miss Lillian Latus, *Chairman*  
Miss Olga Larsen  
Miss Wilma Porter  
Miss Alison MacBride

**Industrial Nurses:**

Mrs. Virginia Ahrendt,  
*Chairman*  
Mrs. Lois Bell  
Miss Virginia Jones

**Office Nurses:**

Mrs. Elizabeth Koenig  
Dr. John W. Devereux

**REPORT FROM LOCAL HEADQUARTERS**

Just about twenty-two months ago I came to these beautiful islands to be your Executive Secretary. As I look back now, I can see that we have accomplished quite a few things since that time. We now have a Counseling and Placement Service which has greatly eased the employment situation here on all the islands. This service is open to all nurses; and, as I have done before, I again urge all nurses to file their credentials even though they do not feel that they want another position right now. It will be there for the future, and some of the people who could write references for you now, might not be here in another few years.

The Association this year has taken part very actively in the legislative program because many important bills were introduced involving nurses and nursing education. The whole group participated also in the Nursing Study made recently by Miss Gillan.

And now, we are still going ahead with our own Economic Security Program. ANA advises us to go on and as you will read elsewhere in the BULLETIN, we are not entirely stopped by the wage freeze.

These are only a few of our major accomplishments and with the interest and enthusiasm among the members of the Association, I am sure you will go on to greater things.

It is with deep regret that I am leaving the islands for I have enjoyed my contacts and my work with all of you. I shall always be interested in the progress of your association and hope to see many of you in the years to come. Aloha and Mahalo Nui.

MABELCLAIRE NORMAN, R.N.  
*Executive Secretary*

**CURRENT INFORMATION ON WAGE STABILIZATION**

ANA assures us that nurses under the present controls can still seek salary increases. Salaries of a high percentage of nurses are now exempt from any specific limitations and even in the case of those nurses whose salaries are still subject to controls, there is no prohibition against the seeking of increases, although certain of

such increases require approval by the Wage Stabilization Board.

Nurses should not be discouraged from seeking the agreement of their employers to increase even beyond present limitations, since new regulations and revisions are constantly being issued. After such agreements between nurses and their employers have been reached, the approval of the Wage Stabilization Board can be sought.

ANA will keep the states informed of any changes and any interpretations as they come out. Wage Stabilization, then, does not mean that we cannot still follow through on our planned Economic Security Program.

**NURSES ASK WAGE BOARD SUPPORT TO OVERCOME CRITICAL NURSE SHORTAGE\***

New York, February—Professional nurses today sounded a warning to the Wage Stabilization Board that "policies which ignore the peculiar problems of nursing will be disastrous" and only lead to "deterioration and depletion of nursing service."

This warning was contained in a statement delivered to Wage Stabilizer Cyrus S. Ching by the American Nurses' Association. The association called on the Wage Board for development of policies which will support present efforts to overcome the critical nursepower shortage.

ANA represents more than 175,000 registered professional nurses in every state, the District of Columbia, Puerto Rico and Hawaii.

"Nurses face extraordinary obstacles in their efforts to improve salaries and to eradicate long-standing conditions of exploitation," the statement declared. Nurses are handicapped in correcting unsatisfactory conditions by their own voluntary surrender of the strike weapon. Also, special exemption of non-profit hospitals from operation of the Labor-Management Relations Act of 1947 handicaps collective bargaining negotiations.

"As a result, the registered professional nurse is at the lowest point, relative to comparable groups in our economy, in many years," the statement pointed out. The nurses fear that imposition of government restrictions on their earnings at this time will precipitate exceptional problems.

Four broad recommendations were made by ANA to the Wage Board "in fairness to members of the profession and in the interest of public welfare." These call for (1) policies which recognize critical manpower needs in nursing, (2) recognition of ANA in developing and administering wage policies, (3) representation of professional nurses on regional and area wage boards through nurses recommended by state nurses' associations, and (4) an immediate survey of working conditions by the Bureau of Labor Statistics to make detailed data available to the Wage Board and other agencies dealing with problems of nursing.

Specifically, the nurses asked that stabilization policies allow for cost-of-living adjustments immediately and in the future, adjustment of inequities within nurse-employing institutions, elimination of discriminatory differentials against minority groups, safeguarding of provisions in existing collective bargaining agreements, and correction of gross inequities resulting from lag in nurses' salaries behind those in other occupations.

\* ANA News Print Release.



Emphasizing the precarious nursepower situation, the statement said there exists a "current deficit of 65,000 professional nurses for civilian services." This will be further aggravated by expanded civilian needs in the present emergency period, and by increased military demands. During World War II, the military alone employed 65,216 nurses.

According to the statement, "the nursing profession remains hard pressed to keep present nurses and to recruit new nurses because of its unfavorable economic position." Nor can large numbers of inactive nurses be induced to return to active practice under present conditions.

Adjustments in nurses' salaries have not kept pace with increased living costs nor with wage trends generally, the statement declares. A nationwide survey made by ANA in October, 1949, showed that general duty nurses—the backbone of hospital nursing service—received an average of \$205 per month, with an average scheduled work week of 44 hours. Current data indicate negligible gains since then. Preliminary reports of ANA's January, 1951 spot-check of 65 non-federal general hospitals in 34 U. S. cities show general duty salaries ranging from \$125 per month, with room and meals, for a 44-hour week of \$275 per month, with no maintenance, for a 40-hour week. Forty-four per cent of these hospitals paid no overtime, and only 13% paid time and one-half. In the short period since July, 1950, unfilled vacancies had risen from 997 to 1,184.

A general trend toward increasing vacancies and consequent increased work loads for nurses in civilian hospitals is evident. In New York City municipal hospitals, for instance, only 57% of the nursing positions are filled in the face of a 100.3% occupancy rate of hospital beds. Overcrowding and chaotic care is the unavoidable result.

The ANA statement was submitted by Miss Ella Best, R.N., Executive Secretary, with an offer to have representatives appear personally before the Wage Board.

#### THE NURSE IN ATOMIC WARFARE DISASTER MISS VIRGINIA JONES\*

Nurses who were in Hawaii on December 7, 1941, know what happens to the civilian population when a bomb is dropped. Even that gives us little conception of what may happen when an atom bomb strikes.

When a mass of radioactive material builds up a chain reaction the fragments of the splitting of one nucleus start the splitting or fission of many others. As this goes on large amounts of energy are given off. When this increasing energy is assembled in a limited space, a violent detonation occurs. This is an atom bomb explosion. The energy is released in the form of blast, intense heat, light, x-rays, gamma rays and nuclear particles.

There may be thousands of casualties, many of whom may die within a few hours. For these nurses can give only comfort to them and their relatives.

There will be many burns from the intense heat of the bomb blast and from fires. It is estimated that 50% of the casualties will have burns. Many will have other injuries as well. These people must be treated to prevent shock and hemorrhage as well as for their burns. Nurses

must be prepared to recognize signs of shock, to determine its severity, and to institute treatment.

There will be many mechanical injuries near the site of the bomb blast. These will be caused by collapsing buildings and falling debris. We may expect 50% of the injuries to be of this nature. Again the nurse must recognize, prevent and treat shock and hemorrhage. She must know how to dress wounds with safe technique without sterile dressings and instruments and without gas and electricity to sterilize them. She must be able to cleanse and even pull wounds together without damage to the wound whether it be minor lacerations from glass or amputated body members. She will often be responsible for determining what casualties remain in the first aid stations, which ones will go home, and which ones will go to the hospital.

There may be persons suffering from radiation injuries. X-rays, gamma rays, and nuclear particles, in sufficient quantity, will cause cell and blood changes in persons exposed. It is estimated that around 20% of the casualties who survive the first twenty-four hours may be suffering from such injuries. This number is less if the bomb bursts in the air because the winds will carry the residual fission products high into the air and scatter them. The amount of radiation contamination will also depend upon whether it is raining and whether mountains or hills divert the spread. The nurse will be expected to determine from the nearness of the person to the blast, the amount of protection afforded him, and his symptoms, what the extent of his radiation injury may be. Those with likely lethal doses must make way for those expected to recover. The course of symptoms such as nausea, vomiting, fever, and prostration indicate the probable prognosis. Therefore, the nurse must be able to observe, record and evaluate symptoms. She must be prepared to administer blood and other fluids to replace missing blood elements caused by radiation and to give antibiotics to combat infection. These patients need rest, good general nursing care, and emotional support.

Monitoring teams will measure radiation hazards and decontamination teams will remove radioactive material from persons and equipment. However, the nurse also must understand the principles of decontamination in order to function in an emergency for the protection of patients, workers, and herself.

There will be babies being born prematurely, infants and children left without parents, persons with diabetes or heart conditions, the aged and infirm, all needing routine treatment and care under disaster conditions.

There will be panic among workers and rescuers as well as among casualties. A certain pattern of behavior may be expected. At the time of the impact the individual is stunned and behaves automatically. Then he may be expected to follow simple directions and to carry out drills previously learned. The recoil period follows for the first twenty-four hours. Then there is likely to be a pouring out of emotions and a great deal of hostility to rescuers. It must be remembered that this is only a temporary phase of behavior. This is the time when rumors of atrocity may be started by those temporarily upset.

A post-traumatic period follows. Ten per cent of the people will recover quickly and assume leadership. Another 10% will recover from their stunned condition

\* Virginia A. Jones, M.Ed., Associate Professor of Public Health Nursing and Chairman, Department of Nursing, University of Hawaii.

but will faint or run or become hysterical. The nurse may expect these reactions from anyone—even from herself. Public education, understanding of the nature and magnitude of the problems, training and assignment for specific functions will decrease the time needed for adjustment.

There will be need for large numbers of workers to assume new responsibilities. Professional nurses might be expected to be responsible for patient screening, treatment and obstetrical deliveries which under ordinary circumstances would be performed by a physician. The nurse's chief function will be the direction and supervision of practical nurses, nurses' aides and other workers. These workers also must be directed to perform duties not ordinarily expected of them.

In order for nurses to meet these responsibilities, plans for their assignment, preparation and pre-disaster functions must be integrated with those of physicians, dentists, radiation monitors, technicians, first aid workers and many other groups of workers. This is a gigantic task which takes time.

The following steps have been taken so that nursing may make its most effective contribution to the Territory's plans:

1. The Nurses Association, Territory of Hawaii, has representatives on the Territorial Coordinating Committee and on the Survey and Assignment Committee.
2. Almost 900 professional nurses and 700 practical nurses are registered for disaster service and are being assigned to hospitals and first aid stations.
3. A pilot group of instructors is formulating plans and developing a manual for classes in nursing aspects of atomic warfare for all nurses in the Territory.
4. Nurses on Kauai and Hawaii are being invited and urged through the District Nurses Association to participate in the day-long courses for physicians to be held in those islands.
5. The Nurses Association, Territory of Hawaii, and the League of Nursing Education are planning to develop refresher courses for nurses who have not been recently practicing nursing.
6. All nurses are being urged to enroll in Red Cross First Aid classes.
7. The Emergency Service Committee of the Territorial Medical Society is being asked to approve standing orders for conditions expected in disaster. Nurses may then be prepared to assume responsibility if a physician is not available. The Committee is also being asked to approve certain techniques which can be standardized throughout the Territory. This will enable nurses to work more effectively in any situation.

#### WHITE HOUSE CONFERENCE

MOLLIE KIRCHGASSNER\*

To You, the Territorial Commission on Children and Youth:

This is my report as one of your delegates to the Mid-Century White House Conference. I went to Washington as an individual resident. I represented no specific group, but I am a nurse and so I saw the Conference through the eyes of a nurse. Thus I must give my report to you.

It was a thrilling experience to sit and listen to such learned people as Leonard W. Mayo, Margaret Mead, Allison Davis and Dr. Benjamin Spock. Both during the workshop on health services, and in the special meeting for professions allied with or related to the field of health, I sat spellbound listening to people talk about things that are so close to the hearts of nurses. I wish every nurse in the Territory could have been with me. What I have to say is simply my interpretation of what was important to my profession.

I start with a quotation: "A fifth in a distinguished series, the Conference will set the pattern of child care for the next decade."

Child care, for the next decade? Yes, that is how it reads. Ten years is a long time in a child's life and your life and mine; but a short time to accomplish all that was recommended for our children. It isn't just more and better medical and nursing schools; it isn't just more and better health centers; it isn't just more and better cooperation with other members of the team. It has to be a change within ourselves—a change in our own feelings and attitudes, and an understanding of the child's feelings, his rights and dignity as an individual.

We have come a long way from rigid schedules to self-demand, but we in the nursing profession need to go much further. It is true we are hampered and held back by tradition, by hospital rules and hospital regulations, but here are some points I gleaned from the Conference:

People are beginning to think differently about children and the way we treat them. There is going to be a big change. We won't just grab Johnny away from his mother but will invite mother to tuck Johnny into bed. We may even invite mother to stay with Johnny, because he needs the security she can give him as much as he needs his tonsils out. We won't whisk Mary off to the operating room and put a mask over her face as she screams and yells in terror. Mother or dad will go along with Mary and give her the feeling of being loved, as she is put to sleep. Don't think this can't or won't happen. It is already being done in some hospitals.

I would like to give you an illustration that was given at the Conference of how a great many children feel about hospitals. At a certain school one day the children were asked to give quick replies to three questions. First, what is a church; second, what is a school; and third, what is a hospital? Their answers were, with very few exceptions, like this: "A church is where I go to learn about *my* religion; a school is where I go to learn to do *my* lessons; a hospital is where *you* go when *you're* sick." We must make the hospital something positive in a child's life. The routine physical examination should also be positive, with the positive findings emphasized and the negative findings explained. Parents and children will then come willingly, and it will be a learning experience for all of us.

Now the handicapped child needs special attention too, but only so far as the handicap is concerned. Because a child has a withered arm or a cleft lip is no reason he can't think for himself and be independent. Our handicapped children need a great deal of assurance and a chance to be with and play with other children. They need wholesome understanding of their disabilities and relief from their anxieties. We need to be close to these children, but not so close that we hamper their growing.

\* Mollie K. Kirchgassner, R.N.—Graduate School of Midwifery—Frontier Nursing Service, Hyden, Kentucky.



Another question that came up was who should administer the school health program. The answer was no one could do the job alone. All concerned must co-operate: the teacher, the physician, the dentist, the nurse, the counsellor, the nutritionist—the entire health team must understand the important contributions of their co-workers. They brought out the fact that we often don't accept or know how to use co-workers who have responsibility the same as ours. It was suggested that students in medical and nursing schools, students in social work and nutrition and all others who will some day need the help and cooperation of other professional groups, learn about them and work with them early in their student days, so it is a well-established habit by the time they are ready to take their places in the community as members of the team.

Nursing has a share in the making of healthy personalities, and it is up to us to stick to the pattern set by the Conference. How we do things to children is just as important as what we do to them.

I began with a quotation and I will end with one: "It takes time to listen to a person; it usually takes time to understand his feelings; it often takes time to help him."

### HOW NOW, NO HOBBY?

Have you a secret yearning to dabble in oils? Tell you what to do . . . go to the Library, get a book on amateur painting, say "Painting for Fun" or "Anyone Can Paint," read, then enroll in a YWCA or University Adult Extension Class, purchase a minimum of equipment (i.e., a 10 inch pyrex pieplate for a palette, a small tin cup for turpentine, a couple of good brushes for oils, size 8 and 10, a small tube each of yellow, blue, red, brown, green, orange, and a larger one of white oils, some window shade which you cut into pieces about 14 by 18 inches) and start painting. What? You can't draw a straight line? Who cares! In no time you would find straight lines dull as ditch water. Mother Nature uses curves and more curves and who are we to ignore her completely?

You'll be amazed how much fun you have right from the start. Your un-straight lines will get along fine when you learn how to knit them together with color. Don't rush off paint-happy and buy yourself a lot of elaborate working tools before you get the hang of it or you may defeat the purpose of this new venture entirely. What purpose? Why, the purpose we read and hear so much about these days, the need for an outlet for Mary so that she can become a well-rounded personality, a better nurse, a happy human being! Besides, think of the chance to unfold that talent you think you have or that one you didn't realize! No . . . you're not too old . . . don't give out feeble excuses. Is it necessary to list those famous people who made history in their 60's, 70's and 80's? Well then, how about Grandma Moses? Never heard of her? My dear, it *is* time you did something about that hobby!

Naturally I'm speaking from personal experience. Now don't keep scanning the papers for the announcement of my one-man show. Just rest assured that oil painting has not only given me many happy hours of exciting recreation, but has also been the means of greater understanding and enjoyment of art, especially modern art that seems so confusing to many. Just wait and see for yourself. In addition you meet the most interesting people!

Get your best pal to start out with you. There's nothing like sharing this new experience with a good friend as thrilled as you are. You can praise and encourage one another and secretly feel that your work is really much better. Later on if Pal drops by the wayside you'll be so well established you'll never miss her. As for your other envious friends who are too lazy or perhaps too timid to follow in your footsteps, in no time at all they will be clamoring for one of your masterpieces!

Remember, you don't have to outdo what's already been done in art. The idea of a hobby is to permit self expression and the development of whatever talent you might have. If there is no talent and you turn out nothing but junk while enjoying yourself thoroughly in the process, that's success with a capital S!

Another thing, you'll be amazed and delighted to discover that you've been blind as a bat all these years to marvelous color combinations in the scenery about you. Bet you've never noticed some of those interesting rock formations, those constantly changing shadows in the valleys, those lush clouds hovering above the mountain peaks. Well then . . . have you noticed the many interesting people you could put on canvas? You won't have time to paint all the fascinating subjects at your elbow daily.

Ah . . . the blessed release from cares of the work-a-day world as your brush flies over the canvas and the best thing you've done yet begins to appear before your excited eyes! Why didn't you get started before? Why didn't someone tell you these things? Hurry . . . get going . . . and by the way . . . you might as well purchase that French beret you've always admired!

V. (for Van Gogh) BUCHANAN, R.N.

### MEMBERSHIP DRIVE

The Membership Committee, Nurses Association, Territory of Hawaii, has received the approval of the Board of Directors to offer a membership award. In order to stimulate and maintain the interest of each district in achieving its potential membership goal, it was decided to offer an award, such as a replica of the Nightingale Lamp. This award will remain at the headquarters of the district acquiring the greatest percentage of its membership goal during the year. It will be moved yearly to the district having acquired the greatest percentage of potential members. However, should any one district retain it for a period of three consecutive years, it becomes the property of that district.

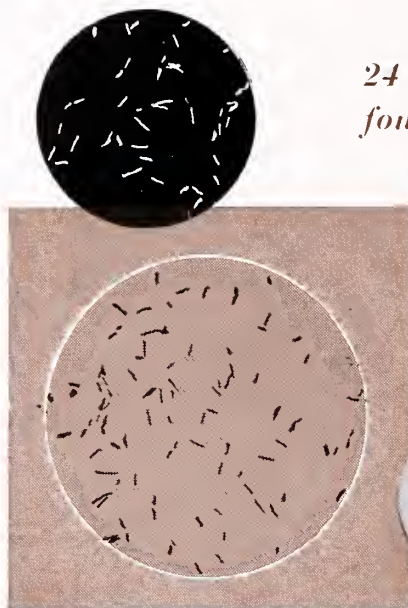
### BE PROFESSIONAL

If you work in a profession, in heaven's name work for it. If you live by a profession, live for it. Help advance your co-worker. Respect the great power that protects you, that surrounds you with the advantages of organization, and that makes it possible for you to achieve results. Speak well of it, stand for it. Stand for its professional supremacy. If you must obstruct or decry those who strive to help, why—quit the profession. But as long as you are a part of a profession do not belittle it. If you do you are loosening the tendrils that hold you to it, and with the first high wind that comes along you will be uprooted and blown away, and probably you will never know why.

CHARLES E. DAWES, *A.N.A. Bulletin*  
(Published in first bulletin in October, 1934)

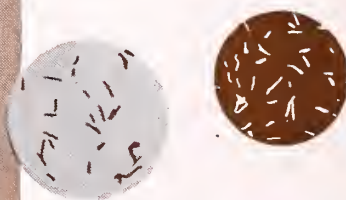


“... OFFERS REAL PROMISE



*24 out of 35 pseudomonas strains  
found sensitive in vitro*

“... nearly three-quarters of the strains isolated in these laboratories are sensitive to therapeutic concentrations of terramycin.”\*



CRYSTALLINE  
**Terra**

*Bacterial resistance usually not a problem*

“During the treatment of the cases described, no resistant mutants originally sensitive strains have appeared; particular attention in respect has been paid to strains of coliform bacilli in urinary infections. In vitro experiments indicate that with some coliform strains a step-like resistance can be evoked, but there has so far been no occurrence of any ‘streptomycin-like’ resistance.”\*

\*Linsell, W. D., and Fletcher, A. P.:  
British M. J. 2:1190 (Nov. 25) 1950.

Antibiotic Division

**Pfizer**

## PSEUDOMONAS INFECTIONS

### *Promising clinically in urinary infections due to pseudomonas*

"Our (latest) clinical results bear out expectations founded on the in vitro activity of the drug..."

"It appears likely that with high dosage, leading to urinary levels of 300-400 mg. per day, practically all cases infected with Ps. pyocyanea will be amenable to therapy..."

### *Promising clinically in superficial infections due to pseudomonas*

"In addition to our findings with the treatment of Ps. pyocyanea infections of the urinary tract, our preliminary data with regard to superficial infections with this organism show that terramycin offers real promise in controlling pseudomonas infections by local or systemic administration..."

# mycin

HYDROCHLORIDE



### *The growing clinical literature continues to stress:*

The broad-spectrum activity of Terramycin against organisms in the bacterial and rickettsial as well as several protozoan groups.

The promptness of response to Terramycin in acute and chronic infections involving a wide range of organs, systems and tissues.

*Supplied:* 250 mg. capsules, bottles of 16 and 100;  
100 mg. capsules, bottles of 25 and 100;  
50 mg. capsules, bottles of 25 and 100.

IZER & CO., INC., Brooklyn 6, N. Y.

## ELIMINATE GUESS-WORK

Guesses and short cuts in determining insurance programs can prove costly. It is safer and cheaper to know.

## REQUEST A SURVEY

of your personal, professional or mercantile insurance needs. It eliminates guess-work by a thorough study and analysis of requirements. Insurance coverages in the proper amounts are "tailored-to-fit" those requirements, to provide maximum protection at minimum cost.



KING ST., BETWEEN FORT AND BISHOP

TELEPHONE 6-3521

## Head Pain as a Diagnostic Lead

Frequently the presence of head pain is overlooked. The physician learns of it only if he has made an effort to elicit the information. Since the etiology of the pain is the basis of rational management, the patient should be warned against taking medication before diagnosis is made.

Friedman<sup>1</sup> deplors the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache—its character, laterality, frequency and intensity.<sup>2</sup>

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic: analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain not related to b. p. level; Dihydroergotamine relieves pain.	General hypertension therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g.i. upset during headache.	To abort attack: oral ergotamine plus caffeine. General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,<sup>3</sup> and Friedman, A. P.<sup>4</sup>

Cecil<sup>5</sup> ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

1) *Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.*

2) *Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.<sup>1,6</sup> The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.*

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 34:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563; Saunders Co., Phila. 5. Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

**Sandoz Pharmaceuticals**

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, NEW YORK



## *To drain the flooded area* **IN CONGESTIVE HEART FAILURE**

"In severe congestive failure, our most dependable remedy is the mercurial diuretic . . . Its combination with theophylline has been a distinct advance."<sup>1</sup>

Salyrgan-Theophylline is a highly effective combination of a mercurial diuretic and theophylline. It may be given orally in certain cases.

Salyrgan-Theophylline is extensively employed for the treatment of cardiac and cordiorenal edema, dropsy of nephrosis and ascites of hepatic cirrhosis. The diuretic response does not "wear out," so that in most cases administration may be repeated as required for years, without loss of efficiency.

Noth,<sup>2</sup> for instance, in discussing a case of Pick's disease, states that the patient "has received about 450 doses of mercurial diuretics, nearly all of which were of Salyrgan given [parenterally] . . . At no time has he experienced orthopnea, nocturnal dyspnea, or episodes of dyspnea while at rest. He is still working every day as a banker . . ."

1. Hutcheson, J. M.: Management of Cardiac Failure. *Virginia Med. Monthly*, 74:458, Oct., 1947.

2. Noth, P. H.: Pick's Disease: A Record of Eight Years' Treatment with Salyrgan, Ammonium Nitrate, and Abdominal Paracentesis. *Proc. Staff Meet. Mayo Clin.*, 12:513, Aug. 18, 1937.

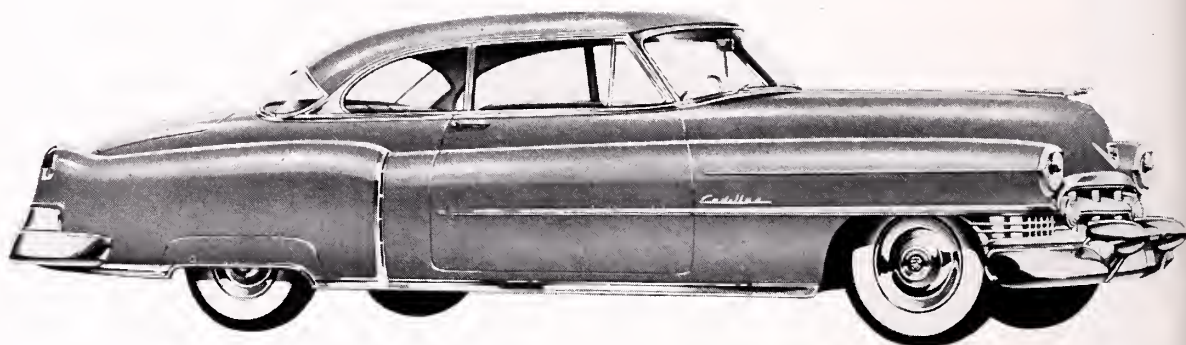
Salyrgan, trademark reg. U. S. & Canada

**salyrgan<sup>®</sup>**  
*theophylline*

BRAND OF MERSALYL AND THEOPHYLLINE

Ampuls (1 and 2 cc.) — Ampins (1 cc.) — Tablets

*Winthrop Stearns* INC.  
NEW YORK 18, N. Y. WINDSOR, ONT.



LIFE  
EXPECTANCY:  
LONG

*Cadillac*

Here is CADILLAC for '51—the automobile designed to serve you as you serve others: dependably, giving only the best, providing comfort and confidence for a lifetime.

Now is the time to come up to Cadillac — the automobile you need, you deserve, you have earned—for profession and for pleasure.

Now more than ever, it is important to invest in the automobile whose active years outnumber those of any other car! Now is the time to prescribe for yourself: Cadillac.



**SCHUMAN CARRIAGE COMPANY**

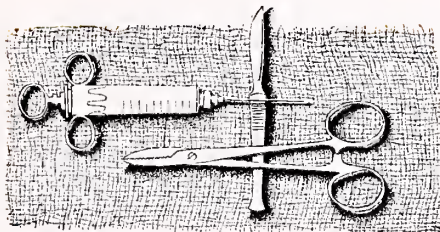
Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU



*Effective against many bacterial  
and rickettsial infections, as well as certain  
protozoal and large viral diseases.*

# AUREOMYCIN

Hydrochloride Crystalline



**The Surgeon** is no longer hampered in his work by the fear of uncontrollable postoperative infections, thanks in large measure to the sulfonamides and the antibiotics. Aureomycin is indicated for preparation of the gut before enteric surgery. The high concentrations attained by aureomycin in the bile make it of particular value in operations on the infected biliary tract. Its efficacy against streptococci and staphylococci, which are becoming increasingly resistant to penicillin, renders its use advisable in surgical conditions where these organisms are actual or potential invaders.

#### *Packages*

*Capsules:* Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.  
*Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION

*AMERICAN Cyanamid COMPANY*

30 Rockefeller Plaza, New York 20, N. Y.






### Some Peptic Ulcer Patients Do Better on Phosphaljel

Clinical experience confirms that certain types of difficult-to-manage ulcer show a more striking and lasting response to PHOSPHALJEL therapy than to other types of medication. Palatable PHOSPHALJEL is the peptic ulcer medication of choice in the following conditions:

- Marginal or jejunal ulcer following gastrojejunostomy.<sup>1</sup>
- Ulcer complicated by deficiency of pancreatic secretion or by diarrhea.<sup>1,2,3</sup>
- Prophylactically, after peptic ulcer surgery, and during seasonal recurrence.<sup>3</sup>

PHOSPHALJEL quickly relieves pain and promotes healing. Excellent for oral therapy, and for intragastric drip therapy.



1. Fauley, G. B., Freeman, S., Ivy, A. C., Atkinson, A. J., and Wigodsky, H. S.: *Arch. Int. Med.* 67:653, 1941.
2. Upham, R., and Chaikin, N. W.: *Rev. Gastroenterol.* 10:287, 1943.
3. Collins, E. N.: *J. A. M. A.* 127:890, 1945.

# PHOSPHALJEL<sup>®</sup>

ALUMINUM PHOSPHATE GEL WYETH

*Wyeth* INCORPORATED, PHILADELPHIA 2, PA.

## GROWING INDUSTRIES FOR A GROWING COMMUNITY



FREE  
BOOKLET



A brief survey of papaya production, packing and processing has been prepared to illustrate the problems and potentials of this young industry. For a free copy, address The Hawaiian Electric Co., P. O. Box 2750, Honolulu.

# PAPAYA...

## fruitful field for expansion

*Hawaii today is working to build new industries to aid in expanding the islands' economy. This series of advertisements calls attention to these forward steps... and to their promise for Hawaii's future.*

An infant industry with a history going back almost to the days of Captain Cook is making a move to provide the islands with another major export.

Rapidly expanding since World War II, the industry today is setting new records in papaya production, packing, processing.

Last year alone it marked these achievements . . . increased orchards from 592 acres to 846 . . . increased production from less than 6,000,000 pounds to 7,750,000 . . . doubled the output of canned papaya products.

Today, papaya is a \$500,000 industry . . . and economists set its potential at a figure nearly ten times as large—a sum that would mean much to Hawaii's economy.

To speed it toward that goal, island business, government and agricultural science have teamed together in an extensive development program. Positive steps are being taken to overcome the obstacles that now block expansion—need for technological advancement and market promotion.

Growers have formed a cooperative to meet the problems on an industry-wide front. Two large projects are directed toward developing new techniques in packing and processing. University of Hawaii economists have surveyed the mainland market.

The industry is betting big sums in land, labor and equipment that there's real gold in this fleshy fruit of Oahu's orchards.

*The development of new industries requires individual initiative and community cooperation. In keeping with this spirit, The Hawaiian Electric Co. is constantly planning ahead . . . building today for tomorrow's needs.*

**THE HAWAIIAN ELECTRIC CO., LTD.**



**BUILDING TODAY for Tomorrow's Needs**



**"In general, symptomatic improvement  
[of menopausal symptoms] was striking within  
7 to 14 days after treatment..." with  
"Premarin."**

*Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.*

Many clinicians have found that "Premarin" therapy usually brings about prompt relief of distressing menopausal symptoms. Furthermore, symptomatic improvement is followed by a gratifying sense of well-being in a majority of cases. This is the "plus" in "Premarin" therapy which tends to quickly restore the patient's normal mental outlook.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

"Premarin" contains estrone sulfate plus the sulfates of equilin, equilenin,  $\beta$ -estradiol, and  $\beta$ -dihydroequilenin. Other  $\alpha$ - and  $\beta$ -estrogenic "diols" are also present in varying amounts as water-soluble conjugates.



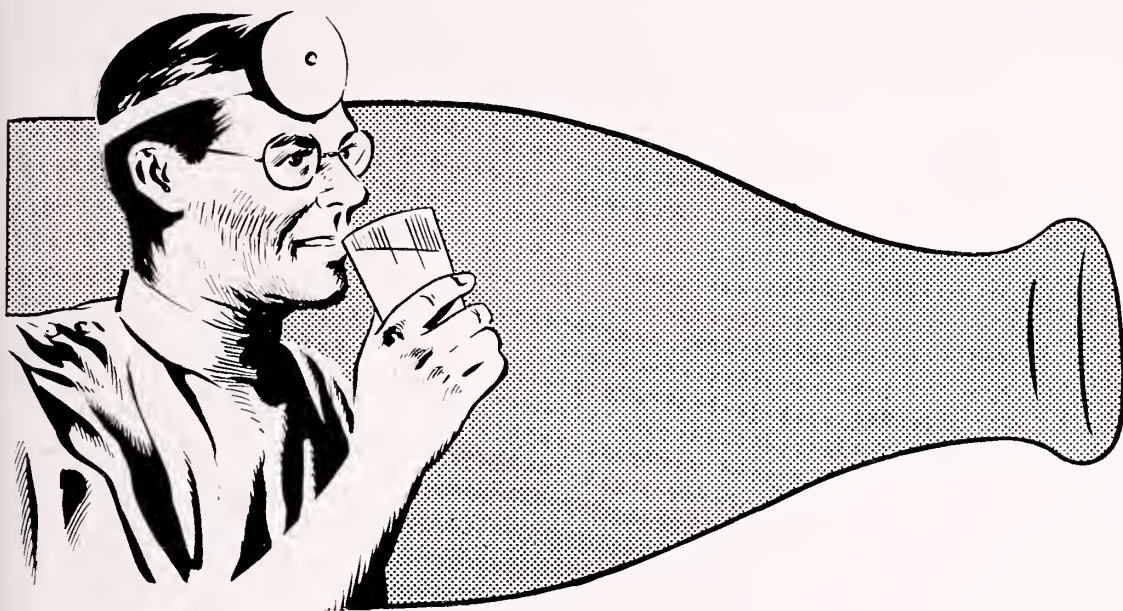
**"PREMARIN"**



*Estrogenic Substances (water-soluble) also known as  
Conjugated Estrogens (equine)*

**Ayerst, McKenna & Harrison Limited**  
22 East 40th Street, New York 16, N. Y.





## *You, Too, May Need More Milk, Doctor*

You're the doctor! We know that *you* know . . . that nobody outgrows the need for milk . . . that adults must keep those bones supplied with calcium throughout life . . . that a quart of milk a day provides 100% of the body's calcium requirement, in its most highly assimilable form . . . that *fresh, whole* milk in its honest-to-goodness original form (nature's own recipe)—is downright delicious to drink.

There is enough fresh, whole milk in Hawaii now, to meet demand—although demand is not yet what it should be (a quart a day for each child and a pint a day for each adult).

One good way to get more people drinking more milk is to recommend it just the way that nature made it.

*Fresh, whole* milk is *naturally* good.

# *Dairymen's* ASSOCIATION, LTD.

*A Division of Creameries of America, Inc.*

**A limited amount of Golden Guernsey, Hawaii's richest milk, produced only by Dairymen's, is now available for home delivery in bottles.**

**Grade AA Milk • Buttermilk • Dari-Rich  
Chocolate Milk Supreme • Non-Fat Milk**

*In bottles at your door; in cartons at your store*

# When the dieter prepares the family fare

By curbing the appetite and elevating the mood, DESOXYN Hydrochloride helps to fortify the patient's resistance to constant temptation. Compared with other sympathomimetic amines, DESOXYN is more potent, weight for weight, so that smaller doses may be used effectively. One 2.5- or 5-mg. tablet before breakfast and another about an hour before lunch are usually sufficient to still the pangs of hunger. With DESOXYN you can expect a low incidence of side-effects plus faster action and longer effect than with other sympathomimetic amines. Try it.

**Abbott**



Prescribe

**DESOXYN<sup>®</sup>** Hydrochloride

(METHAMPHETAMINE HYDROCHLORIDE, ABBOTT)

**TABLETS**

2.5 and 5 mg.

**ELIXIR**

2.5 mg. per fluidrachm  
20 mg. per fluidounce

**AMPOULES**

20 mg. per cc.

For low-calorie  
diets, suggest

**SUCARYL<sup>®</sup>**

Abbott's new heat-stable,  
non-caloric sweetener

\* CYCLAMATE, ABBOTT

## Functional Insomnia

## LIFE IS DARK



*In functional insomnia, DELVINAL® provides calm, restful sleep with relative freedom from unpleasant side effects—patients usually wake refreshed.*

## for light sleepers

DELVINAL is characterized by a relatively brief induction period, moderate duration of action, and a safe therapeutic index.

DELVINAL is indicated for relief of functional insomnia, for pediatric and psychiatric sedation, preanesthetic hypnosis, and obstetric amnesia.

DELVINAL is supplied in *capsules*: 30 mg. ( $\frac{1}{2}$  gr.), 0.1 Gm. ( $1\frac{1}{2}$  gr.), and 0.2 Gm. (3 gr.) • *elixir*: 0.25 Gm. (4 gr.) per fluidounce, in pint and gallon bottles • *powder*: 15 Gm. ( $\frac{1}{2}$  oz.) bottles • *sterile solution*: for intravenous use, 60 mg. (1 gr.) per cc. Sharp & Dohme, Philadelphia 1, Pa.

# DELVINAL®

sodium vinbarbital



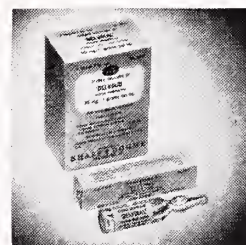
CAPSULES



ELIXIR



POWDER



STERILE SOLUTION

THEODORE H. DAVIES CO., HONOLULU • SOLE DISTRIBUTORS



# 43 YEARS AGO

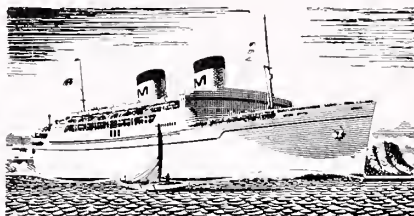
## Matson started passenger Service to Hawaii.... ...and brought a revolution in island Shipping

In 1908 Matson took a revolutionary step. It built the second LURLINE\* and fitted her with attractive accommodations for as many as fifty people, the first passenger ship to sail exclusively the Hawaii-California run. Two years later came an even bigger sensation. Matson launched the WILHELMINA... with the amazing capacity of 146 passengers! Her appointments included the startling luxury of *eleven* bathrooms.

The next few years brought a big increase in travel to and from the islands, due primarily to the fact that Hawaii had a modern passenger service of her own.

Matson has maintained that service for more than four decades. It is carried on today with a great liner that is spaciouly comfortable for over 700 passengers... makes the trip in 4½ days... is one of the finest ships afloat... "Hawaii's own," the third LURLINE. She serves the residents of Hawaii as their favorite means of travel to and from the mainland. She carried more than 35,000 passengers between Hawaii and California in 1950... Hawaii's greatest travel year. The LURLINE represents a service which for more than forty years has been a prime factor in the amazing growth of the tourist industry of Hawaii.

*\*The first LURLINE was a 360-ton cargo brig, built in 1887.*



*Matson Lines*

Pier 9 • Honolulu

## INDEX TO ADVERTISERS

	PAGE		PAGE
Abbott Laboratories .....	396	Merck & Company, Inc. ....	338
Ar-Ex Cosmetics, Inc. ....	378	Parke, Davis & Company.....	326, 327
Ayerst, McKenna & Harrison, Ltd. ....	394	Pet Milk Company .....	339
Borden Company .....	342	Pfizer & Co., Inc. ....	386, 387
Carnation Company .....	328	Philip Morris & Co., Ltd., Inc. ....	332
Dairymen's Association, Ltd. ....	395	Sandoz Pharmaceuticals .....	388
Don Baxter, Inc. ....	333	Schering Corporation .....	329
Eli Lilly & Company .....	325	Schuman Carriage Co., Ltd. ....	390
Hawaiian Electric Co. ....	393	Searle & Co. ....	377
Home Insurance Co. ....	388	Sharp & Dohme .....	330, 331, 397
Hotel Import Co. ....	358	Squibb & Sons .....	334, 335
International Travel Service .....	378	Upjohn .....	399
Lederle Laboratories .....	391	Wander Company .....	337
Matson Lines .....	398	Winthrop-Stearns, Inc. ....	389
McArthur & Summers .....	340	Wyeth, Incorporated .....	336, 392
Mead Johnson & Co. ....	400		



**resistance  
to  
stress**

## ***Adrenal Cortex Extract***

New knowledge of adrenal gland response to stress broadens the use of adrenal cortical therapy in surgery, severe accidents, severe infections, extensive burns. In these conditions of persistent excessive demand, biologically standardized Adrenal Cortex Extract, Sterile Solution, is available for intravenous, intramuscular, or subcutaneous administration. Diminishing response of the adrenal cortex may be offset and recovery speeded with this Upjohn preparation containing all known corticoids essential to life.

*Each cc. of Upjohn Adrenal Cortex Extract contains the biological activity equivalent to 0.1 mg. of 17-hydroxycorticosterone, as standardized by the Rat Liver-Glycogen Deposition test. Alcohol 10%. Supplied in 10 cc. and 50 cc. vials.*



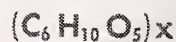
# **Upjohn**

***Medicine...Produced with care...Designed for health***

THE UPJOHN COMPANY, KALAMAZOO 99, MICHIGAN



## Adequate added carbohydrate

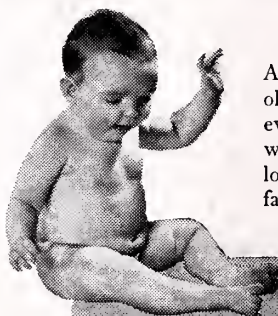


### A necessity for a well balanced infant formula

Added carbohydrate plays an essential role in the infant formula. In adequate amounts, carbohydrate:

1. Permits normal metabolism of fat, thus preventing acidosis.
2. Promotes optimum weight gain.
3. Allows protein to be used to build new tissues rather than to provide calories.
4. Encourages normal water balance.

Cow's milk—Dextri-Maltose® formulas, successful for 40 years, provide optimum amounts of protein, fat and carbohydrate. In accordance with recommendations of authorities, approximately 15% of the calories are supplied by protein, 35% by fat, 50% by carbohydrate.



A typical formula for a 4-month-old infant would consist of 12 oz. evaporated milk, 20 oz. boiled water, 6 tbsp. Dextri-Maltose. Caloric distribution: protein, 15%; fat, 39%; carbohydrate, 46%.

**MEAD'S**

**MEAD JOHNSON & CO.**  
EVANSVILLE 21, IND., U.S.A.



# HAWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

VOLUME 10

JULY-AUGUST, 1951

NUMBER 6



TUBERCULOUS BRONCHOSTENOSIS	OF MEDICINE	
Paul W. Gebauer.....	AUG 27 1951	423
HYPERSPLENISM	LIBRARY	
T. F. Fujiwara.....		429
EFFECT OF PENICILLIN AFTER TOOTH EXTRACTION		
Robert J. Fanning.....		432
REPORT OF CANCER CYTOLOGY LABORATORY		
F. C. Spencer, I. L. Tilden and W. B. Quisenberry.....		437
FEATURES .....		440
INTER-ISLAND NURSES' BULLETIN .....		475
INDEX TO VOLUME 10.....		485

## REMEMBER THIS TERM?



There is little question but that you would  
if you had practiced in 1876, when frontier towns were lawless  
and prescription ingredients were more often variable than uniform  
—and Eli Lilly and Company had just begun.

Then, the prescription request *f.l.a.* (*fiat lege artis*),  
or *let it be done according to the rule*, was appropriate.

Long before legislation made it mandatory

for pharmaceuticals to meet certain minimum specifications,

Eli Lilly and Company had introduced its own high standards of manufacture.

So today there is no need to write *f.l.a.*

when you want to be sure. Specify Lilly.



*Lilly*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.



**AN EFFECTIVE BARRIER**

**PARKE, DAVIS & COMPANY**

BETWEEN

POLLEN AND PATIENT

# Benadryl<sup>®</sup>

ONEER

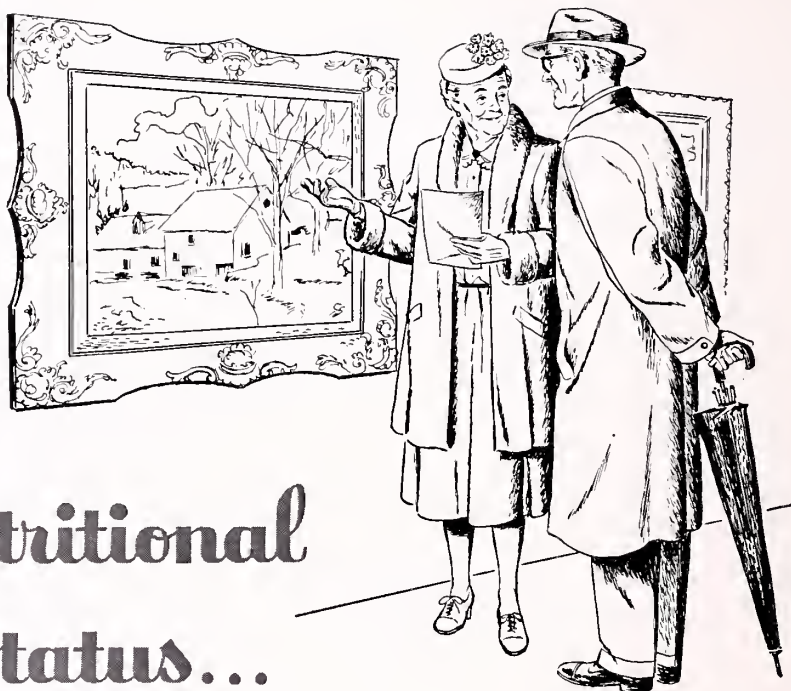
ANTI-HISTAMINIC

When there's pollen in the air, and hay fever on a host of faces, your patients look to you to protect them. Fortunately, in BENADRYL you have a dependable barrier against the distressing symptoms of respiratory allergy.

For your convenience and ease of administration BENADRYL hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a wide variety of forms including Kapseals<sup>®</sup>, Capsules, Elixir and Steri-Vials<sup>®</sup>.







## Nutritional Status...

### AN IMPORTANT FACTOR IN OLD AGE

A RECENT study<sup>1</sup> of the health and nutritional status of 200 elderly patients and their dietary habits revealed their food intake to be deficient in iron, calcium, protein, and, particularly, B complex vitamins. In many instances the lassitude and premature weakness of the elderly are due to such deficiencies.

Correction by increased intake of ordinarily eaten foods often proves difficult. The quantities that would have to be eaten frequently are more than the individual can consume comfortably.

Ovaltine in milk—a tasty, readily accepted and easily digested food supplement—offers a simple solution to this problem. Its wealth of biologically adequate protein, quickly utilizable carbohydrate, and needed vitamins and minerals, serves well in the aim of bringing nutrient intake to optimal levels.

The nutritional contribution of three servings of Ovaltine in milk (the recommended daily amount) is defined in the appended table.

1. Bortz, E. L.: Management of Elderly Patients, Postgraduate Med. 3:186 (Mar.) 1950.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.



## Ovaltine

Three servings of Ovaltine, each made of  
½ oz. of Ovaltine and 8 oz. of whole milk,\* provide:

PROTEIN . . . . .	32 Gm.	VITAMIN A . . . . .	3000 I.U.
FAT . . . . .	32 Gm.	VITAMIN B <sub>1</sub> . . . . .	1.16 mg.
CARBOHYDRATE . . . . .	65 Gm.	RIBOFLAVIN . . . . .	2.0 mg.
CALCIUM . . . . .	1.12 Gm.	NIACIN . . . . .	6.8 mg.
PHOSPHORUS . . . . .	.094 Gm.	VITAMIN C . . . . .	30.0 mg.
IRON . . . . .	12 mg.	VITAMIN D . . . . .	417 I.U.
COPPER . . . . .	0.5 mg.	CALORIES . . . . .	676

\*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

# ***predictable control of hay fever***

Chlor-Trimeton Maleate, milligram for milligram the most potent antihistamine available, allows the physician to predict a definitive and favorable result in symptomatic control of hay fever. Often successful when others fail, and producing few and minimal side effects, Chlor-Trimeton Maleate may supersede other compounds designed for the same purpose.

**Chlor-Trimeton<sup>\*</sup>**  
**maleate tablets**  
(brand of chlorphenpyridamine maleate)

Chlor-Trimeton Maleate is available in 4 mg. tablets.

<sup>\*</sup>T.M.

*Schering* CORPORATION • BLOOMFIELD, N. J.

**Chlor-Trimeton**





## No One Knows Better Than You...A Doctor is Human, Too!

Like thoughtful physicians everywhere, your interest in patients extends beyond professional treatment. For example, you make sure that new babies get proper food, wisely managed, safely prepared for best growth! But you also try to keep cost down... because you know that most parents need every spare penny they can save!

Pet Evaporated Milk helps you solve both problems! It assures babies of optimal nutrition and gives parents maximal economy. Pet Milk is complete in the food values of whole milk... and it's practically as easy to digest as human milk... yet Pet Milk costs less than other forms!

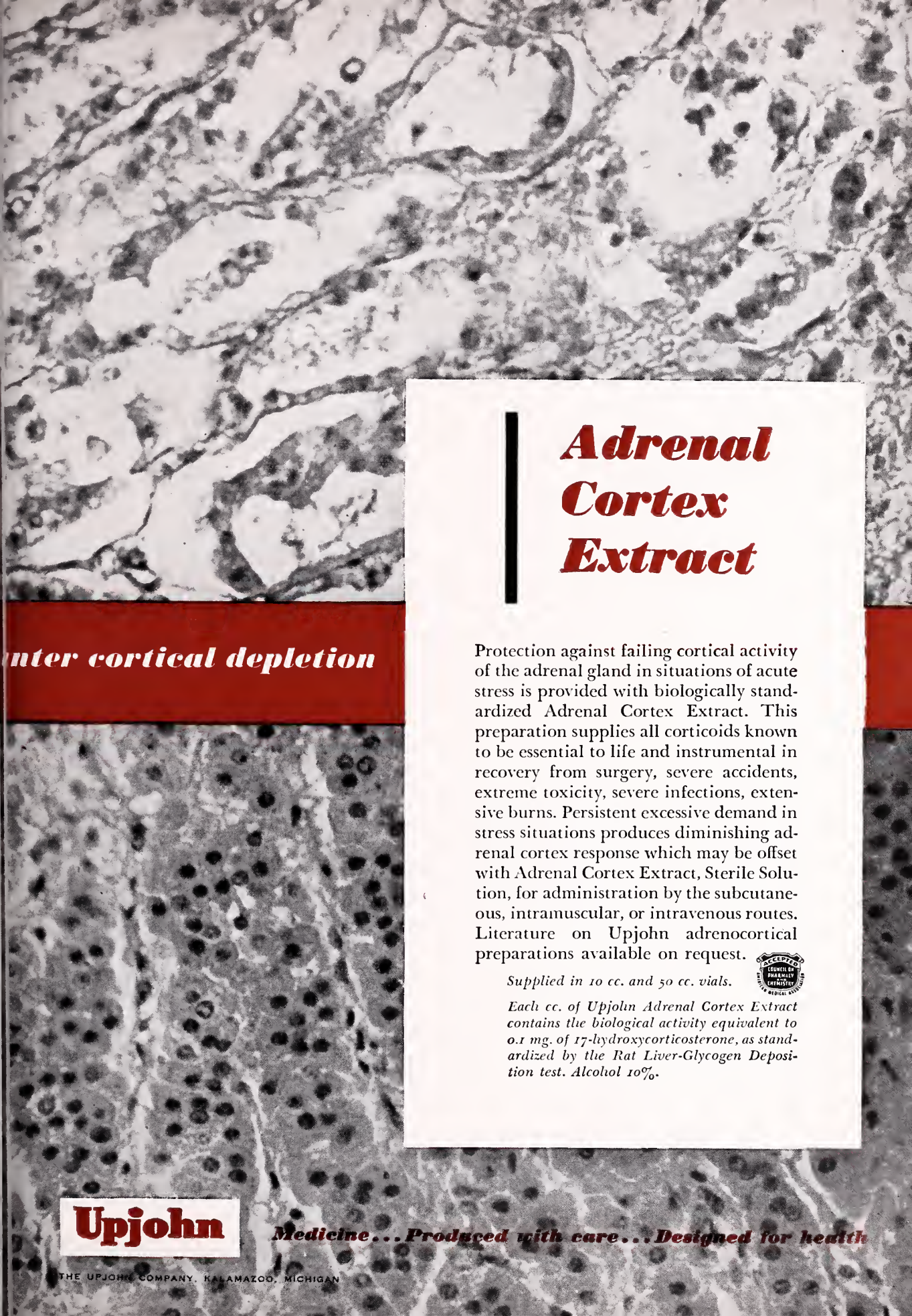
You can be sure of this, too! Pet Milk is always surely safe... as if there were no germs of disease in the world... because Pet Milk is sterilized in a sealed container!

So for safety, nutrition, and economy, too... suggest Pet Milk, *the first evaporated milk*, for the formula of babies in your care!

**Favored for  
Infant  
Formula**







## ***Adrenal Cortex Extract***

***Inter cortical depletion***

Protection against failing cortical activity of the adrenal gland in situations of acute stress is provided with biologically standardized Adrenal Cortex Extract. This preparation supplies all corticoids known to be essential to life and instrumental in recovery from surgery, severe accidents, extreme toxicity, severe infections, extensive burns. Persistent excessive demand in stress situations produces diminishing adrenal cortex response which may be offset with Adrenal Cortex Extract, Sterile Solution, for administration by the subcutaneous, intramuscular, or intravenous routes. Literature on Upjohn adrenocortical preparations available on request.

*Supplied in 10 cc. and 50 cc. vials.*

*Each cc. of Upjohn Adrenal Cortex Extract contains the biological activity equivalent to 0.1 mg. of 17-hydroxycorticosterone, as standardized by the Rat Liver-Glycogen Deposition test. Alcohol 10%.*



**Upjohn**

***Medicine... Produced with care... Designed for health***

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN



*YOU, Doctor, are the best judge, so*

# BELIEVE IN YOURSELF!

With so many claims made in cigarette advertising,  
most doctors prefer to judge for themselves.  
So, Doctor, won't you make this simple test?

**Take a PHILIP MORRIS —  
and *any* other cigarette. Then,**

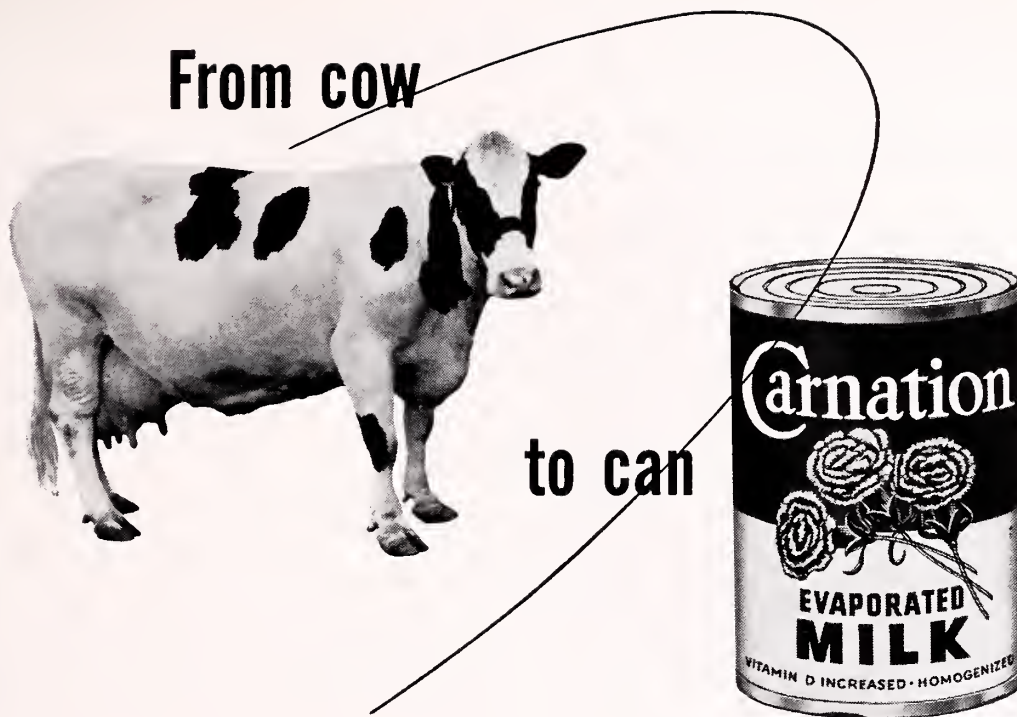
1. Light up either one. Take a puff—don't inhale—and s-l-o-w-l-y let the smoke come through your nose.
2. Now do exactly the same thing with the other cigarette.



*Then, Doctor...BELIEVE IN YOURSELF!*

## PHILIP MORRIS

Philip Morris & Co. Ltd., Inc.  
100 Park Avenue, New York 17, N. Y.



...Carnation protects your recommendation



Every single drop of Carnation is processed with prescription accuracy under Carnation's *own* supervision in Carnation's *own* plants.

This unique "cow-to-can" control is the reason why Carnation is unsurpassed in quality...why it's always absolutely uniform...why you can recommend Carnation with complete confidence.

Don't say "Evaporated Milk"



say **Carnation**

—the milk every doctor knows



*"From Contented Cows"*



## GROWING INDUSTRIES FOR A GROWING COMMUNITY



Substantial supply of locally-produced feed would reduce a \$5,000,000 import.



### FREE BOOKLET

A brief survey of the research work being done to build a new industry from bagasse has been prepared to illustrate Hawaii's opportunities for the future. For your free copy, write The Hawaiian Electric Co., P. O. Box 2750, Honolulu.

## BAGASSE...

*a fuel may become a feed*

*Hawaii today is exploring new industries to aid in expanding island economy—to bring in more money, create new jobs, provide permanent economic security. This series of advertisements calls attention to these steps and to their promise for Hawaii's future.*

**T**he fibrous brown by-product of Hawaii's sugar mills—whose name originally meant "anything worthless"—may one day be the makings of a major island industry.

The product is bagasse, the residue of the cane stalk after juice has been extracted. Nearly two million tons of it are ground out—and burned—every year.

Today, scientists of the Hawaiian Sugar Planters' Association are working to turn this vast resource into feed for dairy cattle and pulp for paper mills—creating new dollars to help expand Hawaii's economy.

It is not now entirely a waste product. Bagasse, burned in huge furnaces to generate steam, keeps the wheels of the sugar mills turning. On the island of Hawaii, small amounts are pressed into wall board.

University of Hawaii and HSPA researchers, however, see greater potentialities, and greater profits for Hawaii in its use for feeding cattle, not furnaces.

Their project, already more than a year old, is still in early stages, only a few months out of the laboratory. A small pilot plant, built to separate the product into pulp for cattle feed and fiber for paper pulp, is now stockpiling feed mixtures for tests this summer at the University and commercial dairy farms.

It is a dramatic project, much of it pioneer research—the building of an industry up from a test tube. It has brought together the skills and facilities of science, industry, agriculture and government in a wide community effort with far-reaching possibilities for Hawaii.

It reflects the ingenuity and imagination that is at work today . . . building growing industries for this growing community.

*The development of new industries requires individual initiative and community cooperation. In keeping with this progressive spirit of growth, The Hawaiian Electric Co., Ltd., is constantly planning ahead, expanding its own facilities and equipment . . . building today for tomorrow's needs.*

**THE HAWAIIAN ELECTRIC CO., LTD.**



**BUILDING TODAY for Tomorrow's Needs**

# Interchangeable and Equally Effective

*Oral*



*Parenteral*

Clinical studies have demonstrated that the therapeutic activity of Cortone\* is similar whether administered parenterally or orally. Dosage requirements are approximately the same, and the two routes of administration may be used interchangeably or additively at any time during treatment.

Although the manufacture of Cortone—probably the most intricate and lengthy synthesis ever undertaken—has imposed unprecedented difficulties, every effort is being made to increase production and, in the meantime, to achieve an equitable national distribution of this vital drug.

*Literature on Request*

Key to a New Era in Medical Science

# Cortone<sup>®</sup>

ACETATE  
(CORTISONE Acetate Merck)  
(11-Dehydro-17-hydroxycorticosterone-21-acetate)

\*CORTONE is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.

COUNCIL  ACCEPTED

**MERCK & CO., INC.**

*Manufacturing Chemists*

RAHWAY, NEW JERSEY

*In Canada: MERCK & CO. Limited • Montreal*





*occurs  
commonly*

*potentially lethal*

# Potassium Deficiency

*easy to overlook*

## KALADEX

(Baxter 0.2% Potassium Chloride in 5% Dextrose Solution)

*provides a*  
**SAFE, FAST, EFFECTIVE THERAPY**

**RECOGNIZE  
THE  
SYNDROME**



Low plasma potassium...EKG changes...profound muscle weakness...respiratory distress

**TREAT  
PROMPTLY**



With KALADEX

**SAFETY**



KALADEX is a *dilute* solution.  
There is *safety* in dilution.

*Eliminate the danger of potassium deficiency. When parenteral potassium is indicated...use*

**KALADEX**



**BAXTER**

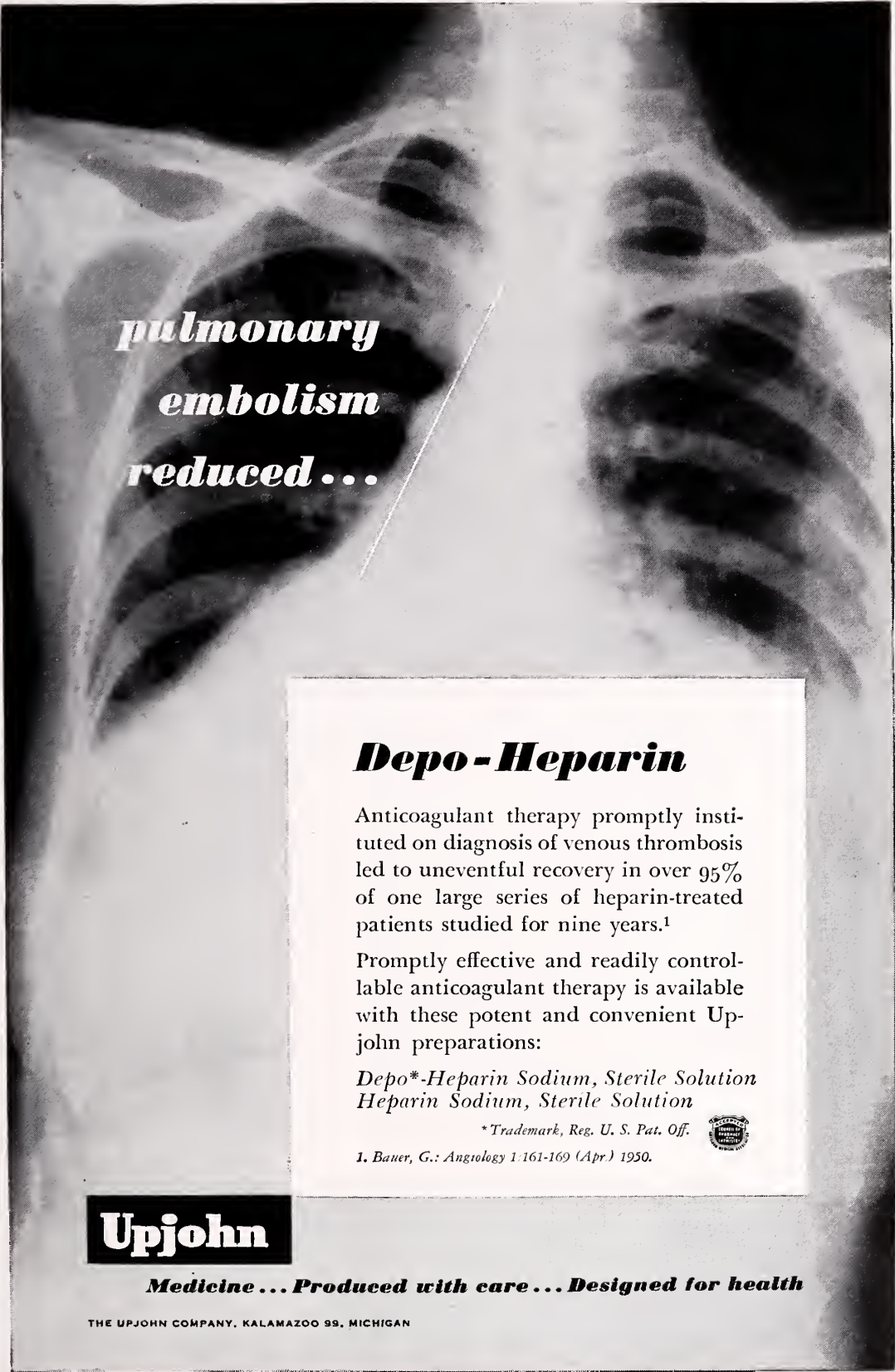
**DON BAXTER, INC.** • RESEARCH AND PRODUCTION LABORATORIES • GLENDALE 1, CALIFORNIA

*Territorial Distributor*

**CROCKETT SALES COMPANY**

P. O. Box 3017, Honolulu, Hawaii • hone 6-8992





***pulmonary  
embolism  
reduced...***

## ***Depo-Heparin***

Anticoagulant therapy promptly instituted on diagnosis of venous thrombosis led to uneventful recovery in over 95% of one large series of heparin-treated patients studied for nine years.<sup>1</sup>

Promptly effective and readily controllable anticoagulant therapy is available with these potent and convenient Upjohn preparations:

*Depo\*-Heparin Sodium, Sterile Solution*  
*Heparin Sodium, Sterile Solution*

\*Trademark, Reg. U. S. Pat. Off.

1. Bauer, G.: *Angiology* 1:161-169 (Apr.) 1950.



# **Upjohn**

***Medicine... Produced with care... Designed for health***

THE UPJOHN COMPANY, KALAMAZOO 99, MICHIGAN

# CONTROL of BLOOD VOLUME

## Restoring Fluid Volume

Plasma infusions, and transfusions of whole blood, often make it possible to restore the circulatory volume satisfactorily without further ado. Sometimes the regulation of water and salt intake will bring about a satisfactory adjustment. Sometimes not. Sometimes all of these measures fail; under certain conditions, it becomes difficult or practically impossible to achieve a satisfactory response without repeated infusions, time after time, or the use of additional measures and long-continued treatment.

## Practical Problems

The problems of management are complicated by the fact that blood volume is difficult to measure accurately, and because there are no simple guides for determining what volume is "normal" for the individual to begin with. "The best that one can do," according to a recent report by Price, "is to say that normal active human adults, with average physiques, have plasma volumes equivalent to between 4 and 5 per cent of the body weight and hema-

tocrit values for venous blood of 40 to 50 per cent."<sup>1</sup> Price notes that Noble and Gregersen<sup>2</sup> and Gibson and Evans<sup>3</sup> "have found the range of variation in groups of healthy men and women actually to be much greater than that." Price points out that calculations of *blood volume* from the *body weight* are only rough estimates, and that they may be misleading because there is no definite or constant ratio between body weight and total blood volume.<sup>1</sup>

## Theoretical Problems

Control of blood volume is further complicated by the number of physiologic mechanisms involved, their conflicting influences, and our imperfect understanding of the factors themselves—and the ways in which they bring about a dynamic equilibrium. Studies on the anterior-pituitary *adrenocorticotrophic hormone* (ACTH), and the *adrenal cortex hormones*, promise to clarify some of the problems. Other studies that have a bearing on this subject are those dealing with the influences of the *antidiuretic hormone* (of the *posterior* pituitary). But one of the latest reports on the

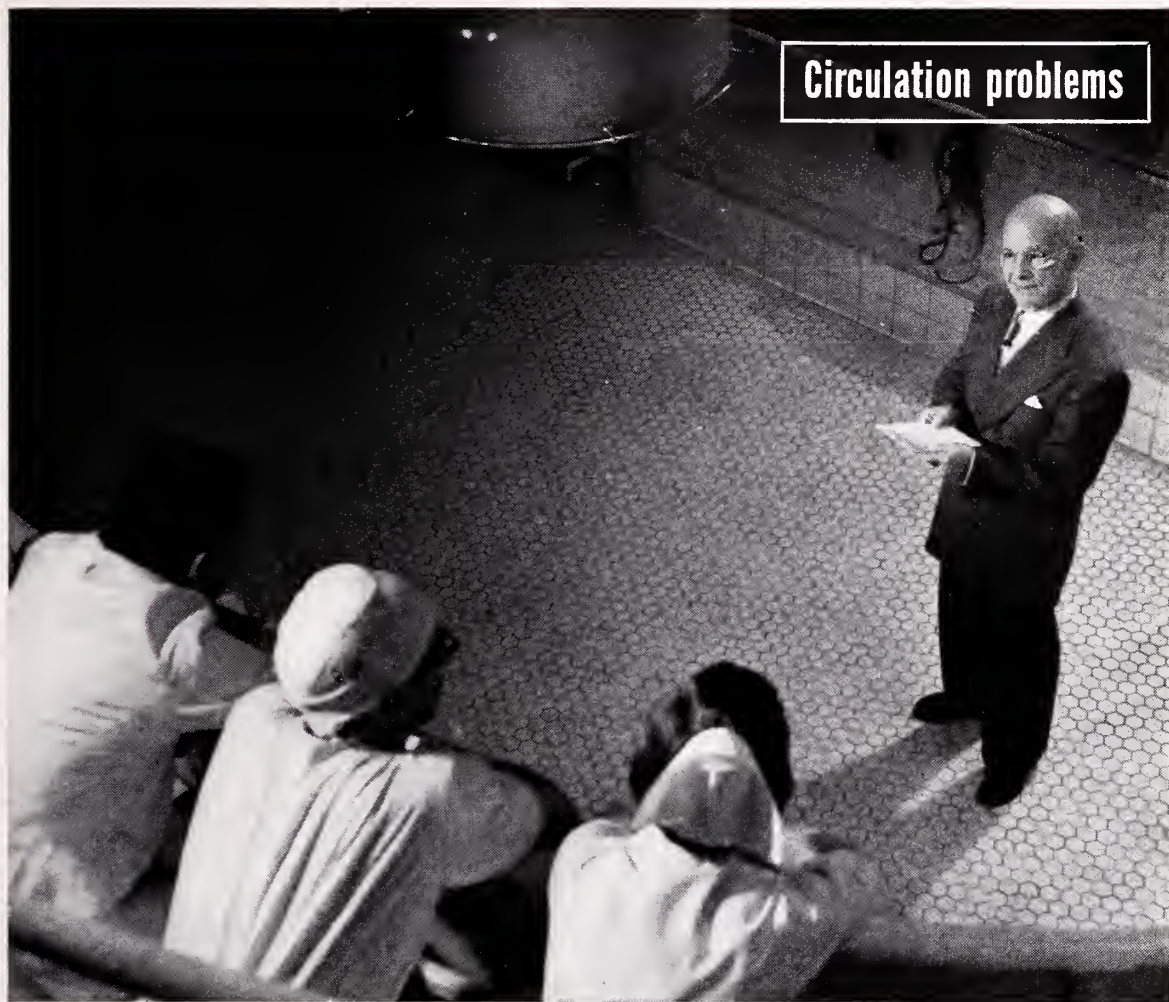
antidiuretic hormone has *added* something to be explained: it was found that the secretion of the antidiuretic hormone was—paradoxically—*stimulated* rather than *diminished* after a high electrolyte concentration had been produced by the mineralocorticoid, desoxycorticosterone acetate.

Studies on ACTH have indicated that this hormone may be useful in increasing and maintaining the circulating volume after plasma or blood has been lost. It causes the retention of sodium (and therefore *water*). In clinical application, however, this effect does not take place until 24 to 72 hours after administration is begun. Consequently it is essential that established measures, such as infusion of plasma or transfusion of whole blood, be employed immediately after severe decrease in the blood volume.

## Disadvantages of Delay

The *dangers* of delay in restoring blood fluid after conspicuous losses—when vascular collapse is imminent—need no further emphasis. Not so generally recognized is the fact that *delay*—in more common but less critical situations—actually





## Circulation problems

... and delay in replenishing the blood fluid makes it difficult to restore the original circulatory volume.

makes it difficult to restore the circulatory volume to the original level. Price<sup>1</sup> emphasizes the importance of this fact in the report cited previously. It would seem that failure to replace fluids promptly makes it difficult to do so at all because the patient's "adaptive" or "compensatory" processes have adjusted his physiologic functions to operate in accord with the new blood volume. Once these adjustments have taken place, attempts to increase the blood volume suddenly are "resisted" in an effort to maintain the equilibrium at the new status. These principles have important practical applications. They indicate the need for replacing blood and plasma, volume for volume, as the losses occur. "Many conditions, surgical and medical, are characterized by reduced blood volume. Restoration of blood volume to normal is an important part of the rational, successful treatment

of those conditions. Good preoperative and postoperative care includes control of blood volume."<sup>1</sup>

### Lyophilized Plasma

Portable, and stable without refrigeration, LYOVAC® Normal Human Plasma (Irradiated) is prepared from fresh, citrated, human blood of carefully selected donors, according to the requirements of the National Institutes of Health. The plasma is pooled, irradiated to reduce the risk of homologous serum hepatitis, rapidly frozen, *dehydrated from the frozen state under high vacuum* (the lyophile process) and sealed under vacuum.

LYOVAC Normal Human Plasma (Irradiated) is supplied desiccated in vacuum bottles to yield 50 cc., 250 cc., and 500 cc. of irradiated normal human plasma (containing approximately 660 mg. of *gamma*

*globulin* in each 100 cc.), or smaller quantities of *hypertonic* plasma (with proportionately higher *gamma globulin* content).

The dosage of plasma will vary greatly, depending on the reduction in blood volume. Although more exact methods of measuring plasma requirements are available, they are technically difficult, and the dose is most commonly determined by measurements of the blood pressure, plasma protein concentration, hematocrit and hemoglobin readings. Plasma infusions are frequently given until those measurements are brought within the normal range.

1. Price, P.B.: Blood Volume in Health and Disease, J.A.M.A. 145:781 (March 17) 1951.
2. Noble, R.P., and Gregersen, M.I.: Blood Volume in Clinical Shock, J. Clin. Investigation 25:158 (March) 1946.
3. Gibson, J.G., and Evans, W.A.: Clinical Studies of the Blood Volume, J. Clin. Investigation 16:317 (May) 1937.

Sharp & Dohme, Philadelphia 1, Pa.

**SOLE DISTRIBUTORS**





JUST WHAT THE DOCTOR ORDERED!

# Cadillac

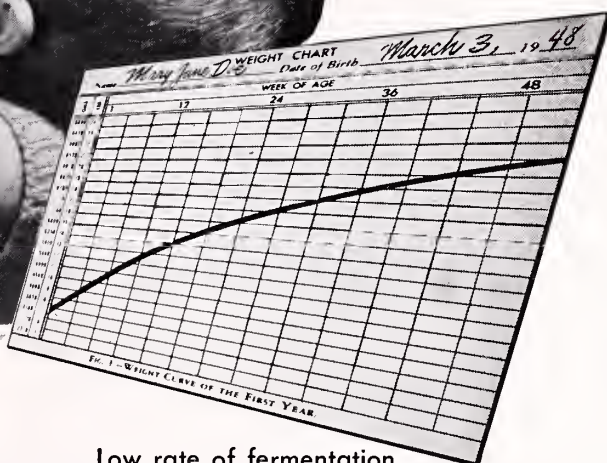
- for '51—a far cry from the horse
- and buggy of the G.P. in days of
- yore! Here are 160 horsepower to
- respond with spirited swiftness,
- when necessary . . . or with luxur-
- ious ease, when you're at leisure.
- Now more than ever, Cadillac is
- the car for the Doctor of today . . .
- the car designed to stay youthful
- in performance, timeless in beauty,
- faithful in service no matter what
- may come in the years ahead.
- Think about it, see it, drive it!



**SCHUMAN CARRIAGE COMPANY**

Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU

# To Maintain a Steady Weight Curve



Cartose is a carefully proportioned mixture of dextrans, maltose and dextrose.

Since each of these carbohydrates has a different rate of assimilation, a steady supply of carbohydrate is released for "spaced" absorption.

Low rate of fermentation.

Low incidence of digestive disturbances.

Bottles of 1 U. S. pint.

Write for formula blanks.

## CARTOSE®

*Specifically  
Designed for Infant Feeding*

**MIXED CARBOHYDRATES IN  
EASY-TO-USE LIQUID FORM**

Compatible with all milk formulas

*Less Colic · Less Diarrhea*

*Winthrop-Stearns* INC. • NEW YORK 13, N. Y. WINDSOR, ONT.



**For The First Time in Hawaii . . .**

# **HOMOGENIZED** *Fresh Milk* **IS AVAILABLE**



## **HAWAII'S MOST EASILY DIGESTED WHOLE MILK**

Dairymen's modern homogenizer breaks the butterfat globules into very fine particles, which remain in suspension throughout the entire bottle. The last drop is as rich as the first. Each glass of milk, poured from the bottle without stirring, is consistently well balanced—with nature's own formula for fresh milk—milk at its best!

## *Dairymen's* **HOMOGENIZED MILK**

Pasteurized! Double-capped for extra safety. Rich: the quantities of butterfat and milk solids are well above territorial requirements for Grade AA whole milk. This premium milk will not be sold at a premium price. The price is the same as for regular Grade AA milk.

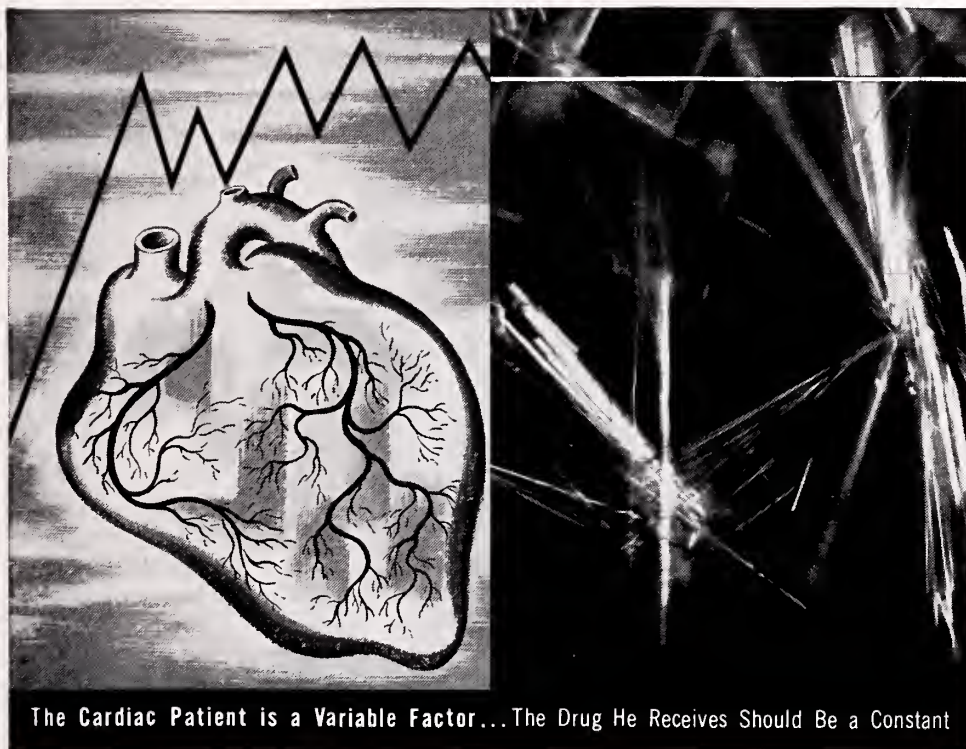
*At Stores, and Available  
for Home Delivery.*

# *Dairymen's*

**RICH, PASTEURIZED  
MILK and DAIRY PRODUCTS**

DAIRYMEN'S ASSN., LTD., A DIVISION OF CREAMERIES OF AMERICA

Photomicrograph (dark field) from a routine production batch of PURODIGIN



**You Expect Patients to Differ** in their responses to a given dose of digitoxin, or individuals to show variations in response at times.

**Adjustments of Dosage** to the patient's requirements can be made with reasonable precision when you use PURODIGIN, because

- PURODIGIN is uniform in potency
- PURODIGIN is completely absorbed, fully utilized

For Flexibility and Precision of Dosage, PURODIGIN is available in graduated potencies: Tablets of 0.05, 0.1, 0.15 and 0.2 mg.



# PURODIGIN<sup>®</sup>

CRYSTALLINE DIGITOXIN, WYETH

*Wyeth* Incorporated, Philadelphia 2, Pa.

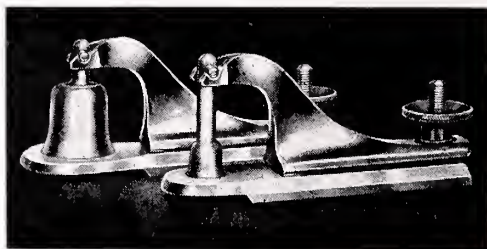
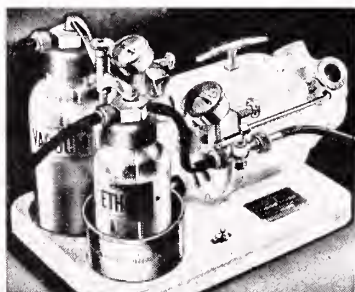


# GOMCO EQUIPMENT



## GOMCO

**SUCTION AND  
ETHER EQUIPMENT**



AT LEFT: ELECTRIC  
BREAST PUMP

ABOVE: CIRCUMCISION  
CLAMPS

*Territorial Distributors*

# HOTEL IMPORT COMPANY

DIVISION OF THE VON HAMM-YOUNG CO., LTD.

*Wholesale Druggists and Hospital Purveyors*

CABLE: "VONHAMYUNG"

718 KAWAIAHAO ST.

P. O. BOX 2630

Honolulu 3, Hawaii, U. S. A.

# HAWAII MEDICAL JOURNAL

and

## INTER-ISLAND NURSES' BULLETIN

Volume 10  
Number 6

JULY-AUGUST, 1951

\$2.00 per year  
35c per copy

Published Bi-Monthly by  
THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
1951-1952

### OFFICERS

HARRY L. ARNOLD, JR., Honolulu.....	President
R. J. MCARTHUR, Wailuku, Maui.....	President-Elect
T. DAVID WOO, Pepekeo.....	Vice-President from Hawaii County
JOHN W. DEVEREUX, Honolulu.....	Vice-President from Honolulu County
K. K. FUJII, Kapaa.....	Vice-President from Kauai County
E. T. SHIMOKAWA, Lahaina.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

### COMMITTEE CHAIRMEN

GROVER A. BATTEN.....	Cancer Committee
TELL NELSON.....	Health Education Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	HAWAII MEDICAL JOURNAL
F. D. NANCE.....	By-Laws Committee
JOHN W. DEVEREUX.....	Advisory Board for Woman's Auxiliary
MORTON E. BERK.....	Diabetes Committee
ISAAC A. KAWASAKI.....	Public Service Committee
VERNE C. WAITE.....	Post-Graduate Committee

### OFFICERS — COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....T. David Woo, Pepekeo	John W. Devereux	K. K. Fujii, Kapaa	Edw. T. Shimokawa, Lahaina
<i>Vice-President</i> .....S. Kasamoto, Hilo	Wm. M. Walsh	Keith Kuhlman, Koloa	John A. Burden, Paia
<i>Secretary</i> .....Francis Wong, Hilo	Wm. S. Ito	C. H. Ishii, Lihue	Edward Kushi, Wailuku
<i>Treasurer</i> .....Richard Hata, Hilo	C. M. Burgess	C. H. Ishii, Lihue	Edward Kushi, Wailuku

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1951, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.





... with a Solid Foundation

For the infant, a sound future depends largely on the kind of nourishment given in the first few all-important months of life.

These are the months when the demand for protein is greatest. And that's one good reason why DRYCO is often recommended when necessary to supplement or replace breast feeding.

It is the 2.7 to 1 ratio of protein to fat in DRYCO formulas that gives this trusted milk such an outstanding advantage, for

it most nearly approximates the balanced *nourishment* and *digestibility* of milk from the human breast.

#### Solid Nourishment—Vitamin Fortified

Always the best fresh milk, modified to provide a ratio of 2.7 to 1 of protein to fat, easily digested, moderate carbohydrate content permitting flexibility, vitamin enriched—and specially packed to retain its original freshness in any climate—that's DRYCO!

Write for detailed information to:

**THE BORDEN COMPANY, Export Division**  
350 Madison Avenue, New York 17, N. Y., U. S. A.

**DRYCO**  
VITAMIN FORTIFIED



# Tuberculous Bronchostenosis

## Pathology and Treatment

PAUL W. GEBAUER, M.D.  
HONOLULU

THIS PRESENTATION reviews and elaborates the pathogenesis of tuberculous bronchostenosis. An illustrative case is presented which exemplifies the two extremes of pathologic physiology that may occur with bronchostenosis, and the successful treatment of this case is portrayed in a colored movie showing the technique of preparing and inserting a tracheobronchial dermal graft.

### Pathology

The increasing use of pulmonary resection for tuberculosis has made non-fatal lung lesions available for gross and histologic study for the first time in sufficient volume and variety. The pathologic changes of excised specimens can be correlated with clinical and radiologic data during the course of the disease, in place of projecting the final, autopsy findings backwards—frequently by surmise—into the clinical picture.

Such studies have not added materially to our knowledge of the pathogenesis of tuberculosis but they have increased our knowledge of clinical tuberculosis, and they are exerting a definite influence in the selection of modern methods of treatment. The material studied at Leahi Hospital is presented in Table 1. In general, this study confirms the findings of Meissner<sup>1</sup>, Wilson<sup>2</sup>, Overholt and Wilson<sup>3</sup>, and Stern and Ehrenreich.<sup>4</sup>

TABLE 1.—*Surgical Specimens.*

Lungs .....	48
Lobes .....	33
2 Lobes .....	5
Lobe & Segment .....	2
Segments .....	7
Total Specimens .....	95

**Incidence of Endobronchial Tuberculosis.** Active or healed tracheobronchial tuberculosis was present in over 60%. The incidence is high because most of the pneumonectomies were done for lungs destroyed by severe bronchostenosis. These patients had been accumulating during the years before surgical excision came into general use.

Read before the Honolulu County Medical Society on February 2, 1951.

<sup>1</sup> Meissner, W. A.: *Surgical Pathology of Endobronchial Tuberculosis*, Dis. of Chest 11:18 (Jan.) 1945.

<sup>2</sup> Wilson, N. J.: *Bronchoscopic Observations in Tuberculous Tracheo-bronchitis*, Dis. of Chest 11:36 (Jan.) 1945.

<sup>3</sup> Overholt, R. H., Wilson, N. J.: *Pulmonary Resection for Tuberculosis Complicated by Tuberculous Bronchitis*, Dis. of Chest 11:72 (Jan.) 1945.

<sup>4</sup> Stern, S. S., and Ehrenreich, T.: *The Pathology of Excised Tuberculous Pulmonary Specimens*, Quar. Bull. Seaview Hosp. 11:149 (Oct.) 1950.

All studies of surgical material are likely to show a high incidence of endobronchial tuberculosis, for this complication usually produces a state that can be treated satisfactorily only by resection. On the other hand, a high incidence of involvement of bronchi adjacent to solid densities (large encapsulated caseous foci, "tuberculomas," inspissated cavities) has been encountered, and such lesions are not prone to produce bronchial symptoms, positive bronchoscopic findings, or clinical evidence of bronchial disease. They are removed because they are unsuitable for collapse, and seldom fade with antibiotic treatment, and the rather unexpected, notable involvement of neighboring bronchi instills the feeling that they are practically always involved, regardless of clinical evidences.

It is reasonable to expect involvement of small bronchi wherever a sizable area of lung destruction has occurred. Central extension, probably lymphatic, of this involvement along the bronchi, as encountered by Meissner<sup>1</sup>, was also common in this study; so that endobronchial tuberculosis now is considered a common accompaniment of pulmonary tuberculosis, and its incidence, as revealed by routine bronchoscopy of sanatorium admissions, represents only the few in whom central extension has reached the range of the bronchoscope.

**Examination of Specimens.** In addition to earlier fixation, this procedure differs from the study of autopsy specimens because of local surgical manipulations which, from a pathologic standpoint, occasionally approach mayhem. However, they are usually necessary manipulations, and unavoidable. The same is true of the mayhem occasionally performed by the pathologist, for he, too, must manipulate.

At operation, the site of the bronchial disease is frequently the region where the bronchus must



DR. GEBAUER



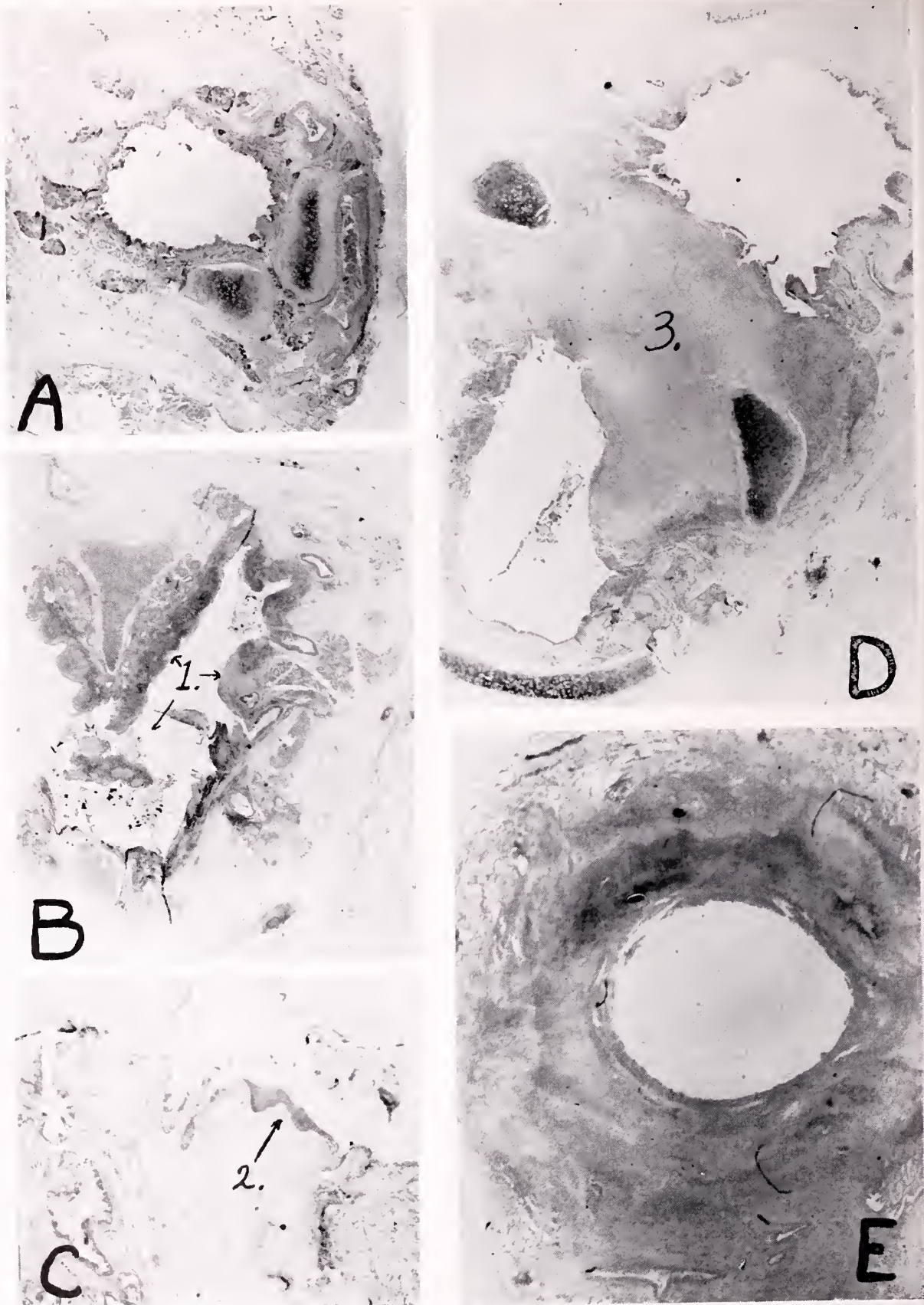


FIG. 1. Five sections of small branch bronchi showing typical changes encountered in endobronchial tuberculosis: A—first branch of bronchus to superior segment of right lower lobe, shows only edema and light lymphocytic infiltration, two intact cartilage plates. B—irregular bronchial lumen contains (1) caseous debris; granulation tissue; sloughed, swollen mucosa. One cartilage plate intact, two others show early disintegration. C—small area of squamous epithelium. D—section through the spur (3) of a branching segmental bronchus shows marked edema and fibrosis; cartilage intact. E—complete necrosis of all elements of bronchial wall; ghost structures could be identified with the microscope.

be divided and sutured; manipulation and suction remove epithelium and exudate, and cause hemorrhage; a clamp on the distal bronchial stump may destroy the region of greatest pathologic change in the specimen. This also happens when the pathologist inserts and ties a tube into a bronchus for purposes of expansion and fixation. Frequently this cannot be done because of multiple bronchial stumps, air leaks through torn pleura, and raw segmental surfaces. Collapsed, fixed specimens, especially segments, are difficult to examine, and the localization of lesions is inaccurate. Information gained from clinical familiarity, and the operative findings of a given case are most helpful in the gross pathologic examination. This is one reason why the surgeon should be capable of a gross examination, and partake in it, if not actually do it.

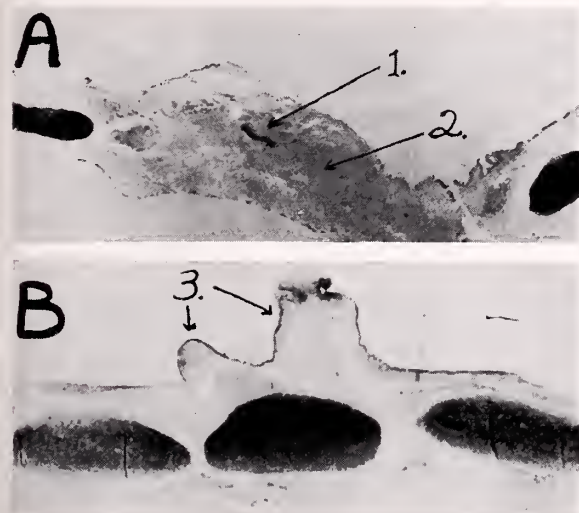


FIG. 2. Longitudinal sections through a healed bronchostenosis: A—shows practically complete replacement of bronchial wall by avascular and acellular fibrous tissue (2). There is a small fragment of residual cartilage (1). B—shows a typical fibrous ridge (3) protruding into the bronchial lumen.

**Degree of Bronchial Involvement.** In the Leahi material all the usual types of tuberculous tracheo-bronchitis were encountered; some of these are pictured in Figs. 1 and 5. They can be divided into the following groups: 1. Light infiltration of lymphocytes. Edema of mucosa and submucosa, with occasional tubercles in the neighborhood of mucous glands. 2. Heavy cellular infiltration. Gross swelling of the bronchial wall and areas of caseation. 3. Large areas of caseation. Mucosal ulceration, and masses of intramural and intraluminal granulation tissue. 4. Complete destruction of the bronchial wall with massive necrosis

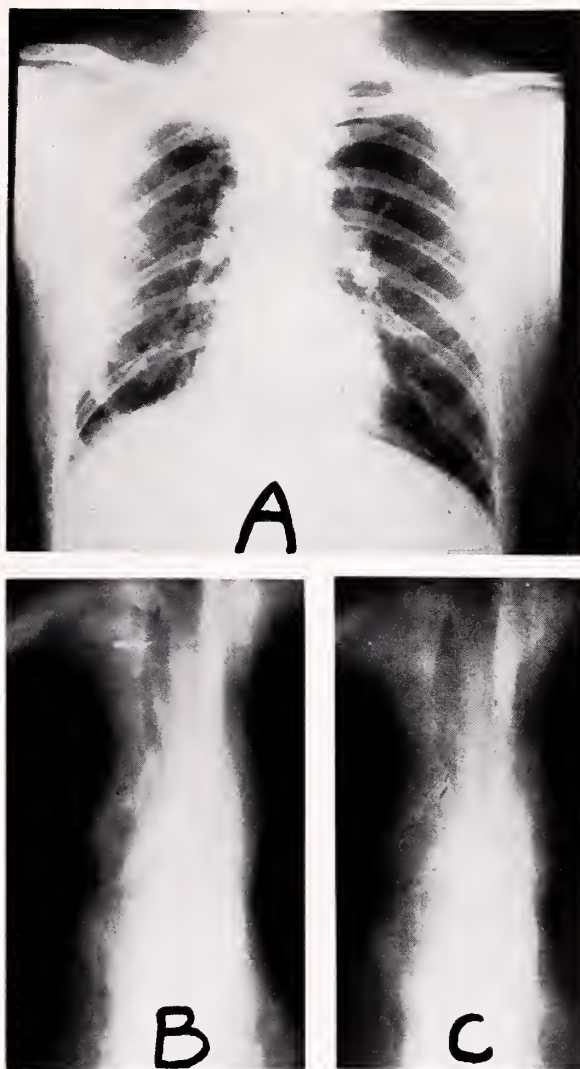


FIG. 3. Preoperative x-rays: A—chest film showing high right hilus and dense apical shadow medially, representing the atelectatic upper lobe. 1945 x-ray appeared the same. B—planigram (unmarked) shows normal trachea, left bronchus, and distal right bronchus. No lumen demonstrated in the proximal right bronchus. C—same as B, marked for better illustration.

and disappearance of the cartilages. Varying degrees of bronchial obstruction usually are detectable clinically in 2, 3 and 4.

**Healing and Stenosis.** Minor involvements appear to heal by the absorption of edema and cellular infiltrates with little anatomic change. Large volumes of granulation tissue are converted to fibrous tissue, and destroyed areas are closed by contracture and fibrosis. Excessive fibrous tissue, or fibrosis and contracture may produce partial bronchial obstruction or bronchostenosis with or without attendant classical clinical symptoms, de-



pending largely upon the degree of bronchial obstruction.

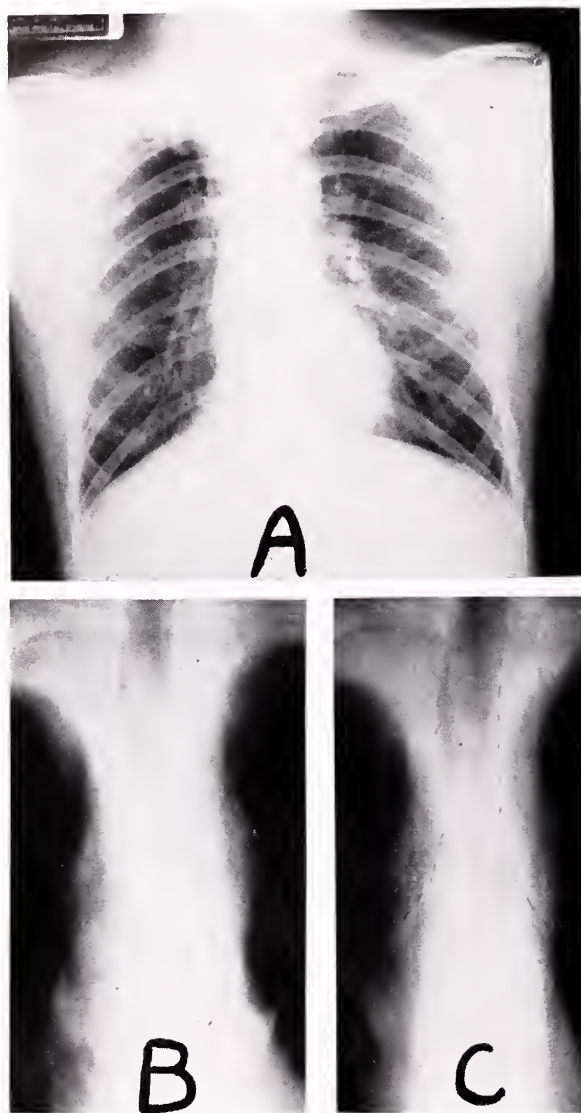


FIG. 4. Postoperative x-rays: A—over four months after right upper lobectomy and dermal graft to stenosed right main bronchus. Right lower and middle lobes well expanded. B and C—planigrams at the same time now show a good lumen in the proximal right main bronchus.

Occasionally a heavy fibrous ring, causing severe obstruction of a short bronchial segment, may show no evidence of previous severe cartilaginous damage. Some of these lesions seem to offer the possibility of simple excision of the intrabronchial ring by surgical bronchotomy for relief of the obstruction. On the other hand, especially in stenosis of appreciable length, evidences of severe cartilaginous damage and loss are plentiful. The entire bronchial wall may consist of a contracted, narrow tube of fibrous tissue exhibiting various

degrees of acellularity and avascularity, isolated fragments of cartilage, and separated areas of muscle and mucous glands, as in Fig. 2, A. The contracture is not only concentric, but also longitudinal, with shortening of the involved bronchus, and notable compensatory adjustment and elongation of the uninvolved neighboring bronchi. A typical example is seen in healed stenosis of the proximal right main bronchus often associated with extensive disease of the right upper lobe bronchus. The case reported herein is an example. The upper lobe bronchus appears to arise from the distal right lateral tracheal wall, and the intermediate and lower lobe bronchi are considerably elongated.

The bronchial lumen may exhibit elevated ridges (Fig. 2, B) and "spider" scars, similar, on a small scale, to the cicatricial contracture of a burned axilla. The lining epithelium is thin and loosely attached. It varies from simple cuboidal epithelium to low pseudostratified columnar with ciliated cells. Bronchial epithelium of normal thickness usually overlaps the periphery of the scar. Metaplasia and squamous epithelium are not uncommon (Fig. 1, C). Occasional concentrations of lymphocytes and plasma cells may be encountered, but tubercles in mature scars are seldom seen.

The frequency and extent of cartilaginous damage and destruction present in severe endobronchial tuberculosis in this experience, and the absence, fragmentation, fibrosis, and even ossification of cartilages revealed in healed bronchial lesions corroborate the conception that the loss of these supportive structures is a major factor in the pathogenesis of bronchostenosis, especially in those instances where an excess of fibrous tissue has not formed. The occurrence of stenosis secondary to cartilage fracture and traumatic laceration of the bronchi also sustains this conception. The following case, the subject of the operative movie, beautifully demonstrates the pathologic changes of bronchostenosis.

### Case Report

K. S., a 34 year old man, had a chest x-ray in 1945 which showed a thin, dense wedge shadow in the medial right apex. A bronchoscopy was performed but the findings were not recorded and the patient was not hospitalized. In July 1949, because of intermittent wheeze, cough, and sputum for two months, he was hospitalized. The sputum was positive, and 42 grams of streptomycin was given from November 1949 to February 1950. The sputum remained positive. In June 1950, bronchoscopy was performed by Dr. Joseph E. Ferkany; an 80% stenosis of the right bronchus at the carina was found.

Physical examination was essentially negative except for harsh, rasping breath sounds on the right. The admission x-ray, Fig. 3, A, showed an atelectatic right upper lobe. Planigrams, Fig. 3, B, C, and bronchoscopy revealed a severe, healed stenosis of the proximal right bronchus. Neither method disclosed an upper lobe bronchial lumen.

On July 26, 1950, the destroyed right upper lobe was resected and the healed, stenosed main bronchus repaired with a wire-supported dermal graft according to the technique previously described in the JOURNAL<sup>5</sup> and elsewhere.<sup>6</sup> At operation, three separate, huge, tortuous bronchial arteries, each of which approached the size of the shrunken pulmonary artery, were identified.

The patient made a good, rapid recovery. Healing of the graft was observed bronchoscopically. At five weeks, curettings from the graft surface showed many ciliated epithelial cells, and after two months, fragments of normal, ciliated bronchial epithelium were obtained. At bronchoscopy 18 weeks after operation, the grafted bronchus easily admitted a scope with an external diameter of 9 mm., and the graft could not be distinguished from the remainder of the bronchial wall. All postoperative sputum cultures were negative. There were no symptoms. Breath sounds were normal and equal bilaterally. At the time of discharge, five months after operation, the preoperative weight was exceeded by three pounds; the x-ray showed little change in the appearance of the right lung field (Fig. 4, A) and the planigram (Fig. 4, B, C) now demonstrated a good lumen in the proximal right bronchus.

The surgical specimen consisted of a shrunken, fibrotic, bronchiectatic lobe with almost complete fibrous replacement of pulmonary parenchyma. The dilated peripheral bronchi were distended with pus. The lobar bronchus was a hard, fibrous core, without demonstrable lumen, containing fragments of ossified cartilage (Fig. 5, A, B). The enlarged bronchial arteries were prominent.

This was an ideal case for bronchial reconstruction, and the result was excellent. Because of the differences between the upper lobe and the remainder of the right lung in the presence of severe main bronchial stenosis, the following discussion seems fitting.

### Pathologic Physiology

The preceding case is a good example of the persistent integrity of lung tissue (the middle and lower lobes, right) in the face of severe broncho-stenosis. It is an even better example of the utter destruction (upper lobe, right) which may occur with broncho-stenosis. The removed upper lobe had become a non-pulmonary structure physiologically; its bronchus was occluded so it did not ventilate, or even trap air. The vigorous demand for "red" blood during its gradual disintegration led to a tremendous hypertrophy of the bronchial arterial system which, through new and enlarged anastomosis with the pulmonary arterial circuit,

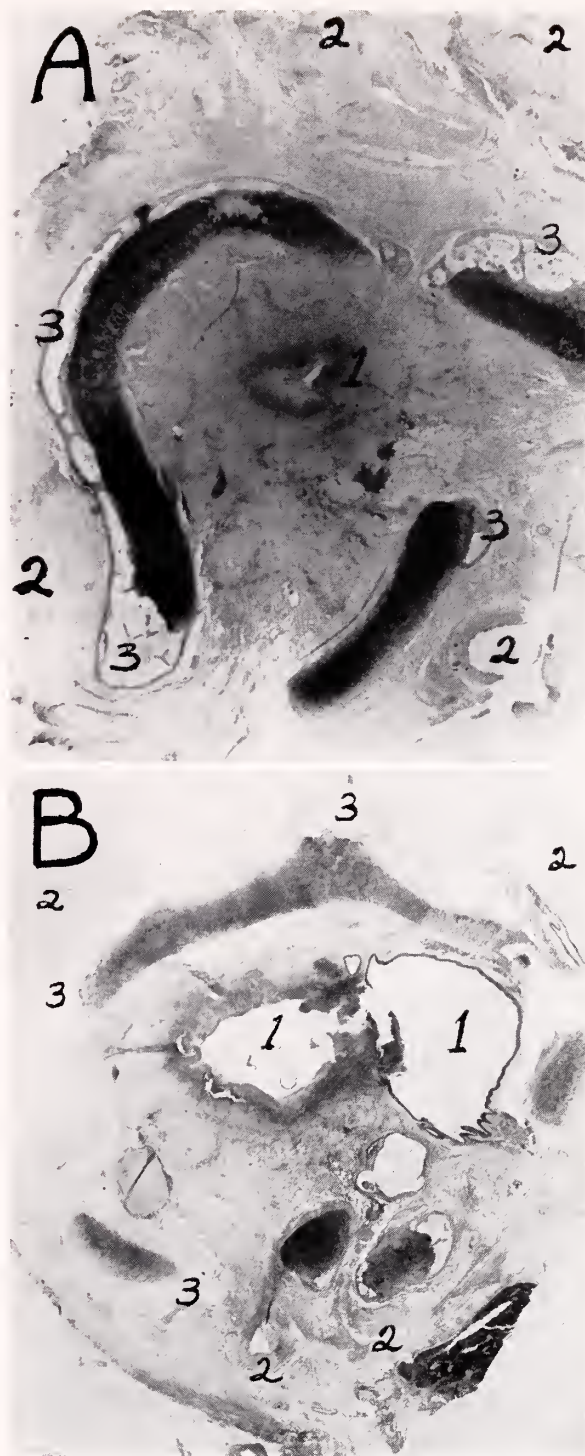


FIG. 5. Sections of right upper lobe bronchus of case reported: A—near point of bronchial division; pinhole bronchial lumen at (1) surrounded by massive tuberculous granulation tissue. Many thick-walled large bronchial arteries (2), ossification (3) of remaining cartilages. Level of section is probably through area of previous branching of the upper lobe bronchus. In B there are two bronchial lumens (1). The left shows the same changes as in A; the right is dilated. Bronchial arteries and ossified cartilages again prominent.

<sup>5</sup> Gebauer, P. W.: Dermal Grafts for Tuberculous Stenosis of the Trachea and Bronchi, HAWAII MED. J. 8:413 (July-Aug.) 1949.

<sup>6</sup> Plastic Reconstruction of Tuberculous Broncho-stenosis with Dermal Grafts, J. Thoracic Surg. 19:604 (April) 1950.



probably invoked either a cessation of pulmonary arterial flow through the lobe, or a reversed flow of systemic bronchial artery blood in the pulmonary arterial bed.

Such physiological adaptations have been surmised for a long time because of clinical observations. The Leahi study includes a great many completely destroyed lungs, most of them representing the survival of years of main bronchial stenosis—images of the upper lobe previously described; namely, whole lungs consisting of giant cavities walled by thick, fibrotic pleurae with barely demonstrable parenchyma, others with practically complete replacement of lung tissue by fibrous tissue and thick-walled cystic bronchi. Such structures are harbored by patients who show no cyanosis, dyspnea, or evidence of arterial oxygen desaturation; it is hard to imagine that they carry a significant pulmonary arterial flow, for the patient seems to tolerate them with the same physiological unconcern he might exhibit for an accessory appendage. In addition, when such a lung is surgically removed, a tremendous systemic circulation is encountered, arising from the chest wall through enlarged intercostal arteries and hypertrophic bronchial arteries while the main pulmonary artery is either normal in size or smaller.

Certainly, the removal of such a thoroughly destroyed lung should not be regarded as reducing pulmonary function by near half; it is more like the amputation of an infected, useless extremity. Particularly, in pulmonary angiography, the failure of intravascular dye to course through a pulmonary artery when traced radiologically is not always indicative of pulmonary artery obstruction, and it is certainly not pathognomonic of malignancy as stated by Neuhof<sup>7</sup>; it can result from central pulmonary artery stasis produced by peripheral bronchial arterial anastomoses which accompany severe inflammatory changes. Our clinical observation and impressions are in thorough agreement with the anatomic studies and experimental observations of Virchow<sup>8</sup>; Wood and Miller<sup>9</sup>; Liebow, Hales and Lindskog<sup>10</sup>; Bloomer, Harrison, Lindskog and Liebow<sup>11</sup>; Cockett and Vass<sup>12</sup>; and Marchand, Gilroy and Wilson<sup>13</sup>.

These workers have demonstrated the rich development, in dogs and man, of precapillary anastomoses between pulmonary and bronchial arteries in diseased states such as bronchiectasis and congenital pulmonic stenosis. In fact, following the experimental ligation of one pulmonary artery in the dog, the deprived lung will show a gradually increasing oxygen absorption, and after four months the blood flow in the ligated side may exceed one liter per square meter of body surface per minute. Such a physiologic adaptation accounts for the clinical improvement following removal of the parietal pleura in congenital pulmonic stenosis when some form of arterial anastomosis is not feasible. Removal of the pleural barrier permits the development of systemic collaterals from the chest wall to the lung which maintains a relatively normal parenchymal pattern. Such anastomoses also occur with severe bronchiectasis and parenchymal destruction or fibrous replacement, whether or not a bronchostenosis contributes to the picture. However, in the absence of severe infection and destruction, we know that simple bronchostenosis itself may not lead to these changes and that good, functioning lung may persist for years distal to a healed bronchostenosis. Just as the middle and lower lobes retained a fairly normal physiologic state in the preceding case, so did they in other cases of much longer duration in this series.

It is not felt that infection is the only deciding factor concerning the functional implications of bronchostenosis, and the preceding points are emphasized to establish the fact that the whole problem of bronchial obstruction and bronchostenosis is dependent on many factors, such as the cause of the obstruction, the type and extent of infection, the duration and degree of bronchial obstruction, and the fate of the pulmonary parenchyma. Stenosis may or may not lead to lung destruction. If the lung structure is not damaged and the stenosis is healed, its reconstruction might salvage good lung tissue. This has been done in 12 of the patients in this Leahi series with highly satisfactory results, by the relief of severe tracheal or bronchial strictures with wire-supported dermal grafts.

<sup>7</sup> Neuhof, H.: Discussion on Angiocardiology, *Jour. Thoracic Surg.* 18:896 (Dec.) 1949.

<sup>8</sup> Virchow, R.: *Virchows Arch. f. Path. Anat.* 1:1, 1847; 3:427, 1851.

<sup>9</sup> Wood, D. A., and Miller, M.: The Role of the Dual Pulmonary Circulation in Various Pathological Conditions of the Lungs, *Jour. Thoracic Surg.* 7:648 (Aug.) 1938.

<sup>10</sup> Liebow, A. A., Hales, M. R., and Lindskog, G. E.: Enlargement of the Bronchial Arteries, and Their Anastomoses with Pulmonary Arteries in Bronchiectasis, *Am. Jour. Path.* 25:211 (March) 1949.

<sup>11</sup> Bloomer, W. E., Harrison, W., Lindskog, G. E., and Liebow, A. A.: Respiratory Function and Blood Flow in the Bronchial Artery after Ligation of the Pulmonary Artery, *Am. J. Physiol.* 157:317 (May) 1949.

<sup>12</sup> Cockett, F. B., and Vass, C. C. N.: The Collateral Circulation of the Lungs, *Brit. Jour. Surg.* 38:97 (July) 1950.

<sup>13</sup> Marchand, P., Gilroy, J. C., and Wilson, V. H.: An Anatomical Study of the Bronchial Vascular System and Its Variations in Disease, *Thorax* 5:207 (Sept.) 1950.

Leahi Hospital, Honolulu.

# Hypersplenism

T. F. FUJIWARA, M.D.  
HONOLULU

UNDER normal conditions, the spleen has been known to function as a filter and disintegrator of the worn out cellular elements of the circulation. The effete cells are destroyed by the normally present hemolysins within the extensive sinusoidal spaces, and also phagocytized by the abundant histiocytes of the organ. The striking rise in the cellular elements, particularly the platelets and leucocytes, immediately after splenectomy, indicates a regulatory influence of the spleen upon the production of these cells.

A variety of hematologic conditions mediated directly or indirectly by an overactive spleen have been designated as "hypersplenism"<sup>1</sup>. The enlargement of the organ, due to any cause, is accompanied in this condition by a drastic reduction in any or all of the cellular elements of the circulation. The views regarding the mechanism of this have been controversial. Wiseman and Doan<sup>2</sup> believe the cause to be an increased sequestration and phagocytosis of the cells within the spleen. They consider the accelerated proliferative activity of the bone marrow accompanying this condition to be secondary to the demand elicited by the cytopenia. Dameshek<sup>3</sup>, on the other hand, attributes the cell reduction to a hormonal influence upon the bone marrow, suppressing the delivery of the cells into the circulation. He bases his theory upon the finding of a hypercellular marrow due to increased numbers of immature precursors of the deficient cellular elements.

Rather than the elaboration of hormonal substances (which have not been demonstrated) the regulatory mechanism may well be a selective or overall influence of the spleen upon the metabolism of the enzyme system of the marrow cells. The selective, regulatory action of vitamin B<sub>12</sub> upon the maturation of the erythrocyte is well known. It is possible that there are as yet undiscovered enzymes which have selective actions upon the other cell precursors, which are mediated by the reticuloendothelial system, of which the spleen constitutes the largest single unit. That such a relationship probably exists is suggested not

only by the quantitative increase of all the circulating cells, but more strikingly by the qualitative changes in these cells for following splenectomy. The erythrocytes produced are thinner than normal and many of the cells contain nuclear fragments (Howell-Jolly bodies), indicative of an abnormal shedding of the nucleus. Probably all the mechanisms described above play a part in the production of this syndrome.



DR. FUJIWARA

## Pathology of Hypersplenism

There is no pathognomonic feature of the hypersplenic spleen. The most consistent finding has been hyperplasia of the reticulum cells, most pronounced in the hemolytic diseases<sup>4</sup>. Stagnation and sequestration of the cells in the pulp and sinusoids have usually been observed. Phagocytosis of the cellular elements are reportedly observed in specimens studied with the supravital stain<sup>2</sup>. However, this process alone cannot account for the tremendous cell destruction that must occur in so drastically reducing the circulating cells.

## Diagnosis of Hypersplenism

An unexplained cytopenia in the blood, accompanied by splenomegaly and evidence of normal or increased cellularity of the bone marrow, are necessary conditions for the diagnosis of hypersplenism. The finding in the marrow of increased numbers of precursors of the cells which are deficient in the circulation further strengthens the diagnosis. A transient increase in the cells after injection of adrenalin is also helpful in establishing the diagnosis<sup>5</sup>.

## Types of Hypersplenism

The condition may be divided into a primary type, in which the etiology of the splenomegaly is unknown, and the secondary type, wherein the

Read before the Sixty-first Annual Meeting of the Hawaii Territorial Medical Association, Honolulu, May 3, 1951.

<sup>1</sup> Dameshek, W.: The Spleen: Facts and Fancies, *Bull. N.E. Med. Center* 3:304 1941.

<sup>2</sup> Wiseman, B. K., and Doan, C. A.: Primary Splenic Neutropenia, *Ann. Int. Med.* 16:1097 (June) 1942.

<sup>3</sup> Dameshek, W., and Estren, S.: The Spleen and Hypersplenism, New York, Grune & Stratton, 1947.

<sup>4</sup> Von Haam, E., and Awany, A. J.: The Pathology of Hypersplenism, *Am. J. Clin. Path.* 18:313 (April) 1948.

<sup>5</sup> Wright, C. S.; Doan, C. A.; Bouroncle, B. A., and Zollinger, R. M.: Direct Splenic Arterial and Venous Blood Studies in the Hypersplenic Syndromes Before and After Epinephrine, *Blood* 6:195 (March) 1951.



splenic enlargement is due to a known cause. Both of these types may be further segregated into different groups, depending upon the hematological manifestations:

1. Neutropenia, with or without thrombocytopenia;
2. Pancytopenia in which the anemia is hemolytic;
3. Pancytopenia in which the anemia is not hemolytic.

Generally, the neutropenia is accompanied by weakness, fever, recurrent infections and polyarthralgia. When the anemia is predominant, pallor, weakness and fatigue are the usual complaints. Jaundice usually denotes a hemolytic component. An abnormal bleeding tendency implicates the thrombocytes.

When confronted with an anemia which cannot be explained on the basis of hemorrhage, nutritional or liver extract deficiency, etc., one must determine whether it is hemolytic or non-hemolytic in type. In the former, jaundice and evidence of increased proliferative activity of the erythrocytes in the blood and bone marrow are the necessary findings. This is characterized by increased numbers of reticulocytes and normoblasts in the peripheral smear and a normoblastic hyperplasia in the marrow. Elevation of the indirect bilirubin in the blood and increased excretion of urobilinogen in the feces are unequivocal evidences of a hemolytic jaundice.

When the condition is secondary to some other disease, the hemolytic anemia is of the acquired type. Circulating hemolysins are usually demonstrable. The Coombs' test is usually positive. The hemolysis is caused by the action of increased amounts of antibodies (hemolysins and agglutinins), produced by the reticuloendothelial system, upon the normal erythrocytes. Since blood stasis accelerates such interaction, the hemolysis takes place, to a large extent, within the spleen. A significant increase in the free hemoglobin in the serum after such a hemolytic crisis indicates that the blood destruction also occurs within the circulation<sup>6</sup>. Since splenectomy only removes an important site of cell destruction, but does not eliminate the entire source of antibody production, the operation can only be expected to be of a temporary or partial benefit. The use of ACTH and cortisone may be a helpful supplement in these cases.

The familiar type of hemolytic anemia will show a prominent spherocytosis and increased fragility to hypotonic saline solution. Since this disease is due to a congenitally defective cell, no abnormal circulating hemolysin can be demon-

strated. The Coombs' test will be negative. The absence of a rise in the free hemoglobin in the circulation during crisis, indicates that the hemolysis occurs entirely in the spleen and the reticuloendothelial tissue. By removing the important site of blood destruction in the familial type, acute and excessive hemolysis is prevented. The effect is a cure.

Occasionally, the splenic anemia may be non-hemolytic. In contrast with the hemolytic variety, there is no evidence of erythrocyte proliferation in the peripheral smear. However, the bone marrow shows normal or increased normoblastic hyperplasia. This condition may also be either primary or secondary and is benefitted by splenectomy.

In splenic neutropenia, one finds only a few mature granulocytes in the blood, associated with a pronounced granulocytic hyperplasia in the bone marrow. It is most important, and sometimes very difficult, to distinguish it from aleukemic leukemia. In the latter, the blood smear will usually show an occasional blast cell, and the anemia and thrombocytopenia are more pronounced. The predominant cells in the marrow are also more primitive and there is usually a more complete displacement of the marrow by the leukemia cells. In addition to some other features of leukemia that may be present, such as lymphadenopathy and a generalized bleeding tendency, the clinical course will be rapidly and progressively downhill. Patients with splenic neutropenia usually remain more or less stationary in their course for months and frequently years. A distinct improvement in the general health and blood picture follows splenectomy.

Thrombocytopenia is frequently primary or idiopathic. Sometimes, it may be secondary to some other disease and may present alarming hemorrhagic manifestations. Such was our experience in two cases of systemic lupus erythematosus and one case of Gaucher's disease. Death from hemorrhage would have undoubtedly occurred, had emergency splenectomies not been performed. One of the lupus cases died a few months later from another complication and the other is, to my knowledge, still alive and in fairly good health over three years after the bleeding episode.

The hematologic findings are similar in both the idiopathic and secondary types of thrombocytopenia. There is a marked reduction in the blood platelets and the bone marrow is generally moderately hyperplastic. There is usually an increased number of megakaryocytes with many immature forms. A remarkable scarcity of platelets in the marrow smears is equally striking. Al-

<sup>6</sup> Crosby, W.: Personal communications.

though the clotting time is normal, the clot is soft and does not retract satisfactorily. No circulating anticoagulants are demonstrable.

Perhaps thrombocytopenia is the most common as well as the most dangerous manifestation of hypersplenism. Yet, the splenomegaly is the least pronounced in the primary type; the organ is frequently normal or even reduced in size<sup>7</sup>. In the secondary type, splenomegaly is invariably present. Splenectomy is curative in the primary thrombocytopenia. Recurrence of this disease, as well as of the other primary hypersplenic syndromes, may be prevented by a careful search and removal of all accessory splenic tissue. Although the underlying disease may not be altered, splenectomy in the secondary types may be life-saving.

Except in emergencies, when the bleeding continues unaltered despite two or three blood transfusions, the decision as to the advisability of splenectomy and as to when it should be performed may be troublesome. Excellent response may invariably be expected when the thrombocytopenia is accompanied by a pronounced megakaryocytosis in the marrow. The frequency of relapse and danger of cerebral hemorrhage are strong indications for splenectomy in the adult. Since the disease often undergoes a spontaneous remission in children, the decision for operation must not be hastily made. When the purpura is severe and the remission is not spontaneous, splenectomy should be done. Surgery should be seriously considered in case of a secondary recurrence of the disease. A high degree of eosinophilia, not reflected in the peripheral blood, has been found to be prognostically more favorable in its outcome<sup>8</sup>. Splenectomy may be extremely dangerous when the megakaryocytes are actually reduced in the marrow, or when there is bone marrow destruction by chemicals, radiant energy, or allergy, or displacement by leukemia, other malignancy, or fibrous connective tissue.

### Contra-indications for Splenectomy

Contra-indication for splenectomy is absolute in cases of sclerosis of the marrow with myeloid metaplasia of the spleen<sup>9</sup>. Here, the bone marrow is practically devoid of hematopoietic cells, and the spleen, like the rest of the reticuloendothelial tissues, has resumed its fetal function of blood cell formation. Removal of the spleen will deprive the patient of an important source of

blood cells. The cause of the sclerosis may be unknown, or it may follow polycythemia or destruction of the marrow by chemicals and radiant energy. Clinically, the splenomegaly is usually accompanied by hepatomegaly and lymphadenopathy. The blood shows varying degrees of anemia, thrombocytopenia and leucocytosis. The presence of normoblasts and immature granulocytes presents a "leukemoid" picture.

Splenectomy should not be performed in leukemia and the various forms of lymphomas. The occurrence of a severe hemolytic complication in selected cases may be a rare exception to this rule. Unless the hypersplenic influence is of a serious nature, splenectomy is not indicated in sickle-cell anemia and Cooley's anemia. In addition to the troublesome mechanical burden of a large spleen in Cooley's anemia, the hemolytic process is significantly reduced after splenectomy in both of these conditions. In Gaucher's disease occurring in children, splenectomy must be seriously considered as soon as the spleen begins to show progressive enlargement. An early removal will undoubtedly reduce the risk involved, because of the smaller size and minimal hypersplenic manifestations<sup>10</sup>.

Congestive splenomegaly due to intrahepatic obstruction, such as cirrhosis, does not respond very favorably, aside from the hematologic improvement. However, it is felt that splenectomy, or simple splenic artery ligation in selected cases, is still the best treatment available at the present time<sup>11</sup>. More favorable results can be expected in splenomegalies due to extra-hepatic causes, such as splenic and portal vein thromboses. When one is contemplating splenectomy in these cases, it is advisable to ascertain the status of the liver by an evaluation of the serum proteins, liver function tests, and most important, liver biopsy. If there is no significant liver damage, then splenectomy will be more justified.

### Summary

Although not essential to life, the spleen has many functions which, when abnormal or excessive, may jeopardize one's well-being and even life itself. Such dysfunctions frequently occur when the spleen becomes enlarged from any cause, and are reflected in disturbances of the composition and normal functioning of the blood. Such a condition has been designated as "hypersplenism." The removal of the spleen has been frequently found to be necessary to correct such disturbances.

<sup>7</sup> Ehrlich, L., and Schwartz, S. O.: Splenomegaly in Thrombocytopenia, *Am. J. Med. Sci.*, 221:158 (February) 1951.

<sup>8</sup> Schwartz, S. O., and Kaplan, S. R.: Thrombocytopenic Purpura: The Prognostic and Therapeutic Value of the Eosinophilic Index, *Am. J. Med. Sci.* 219:528 (May) 1950.

<sup>9</sup> Jackson, H.; Parker, Jr., R., and Lemon, B. S.: Agnogenic Myeloid Metaplasia of the Spleen, *New Eng. J. Med.* 222:985 (June 13, 1940).

<sup>10</sup> Abrahamsen, H., and Krarup, N. B.: On Splenectomy with Special Reference to Indications, *Acta Med. Scand. Supp.* 213:9 (1948).

<sup>11</sup> Collier, F. A.; Blain, A., and Andrews, G.: Indications For and Results of Splenectomy, C. C. Thomas, Springfield, Ill. 1950.



# The Effect of Penicillin Upon Bacteremia Following Tooth Extraction

ROBERT JOSEPH FANNING, D.D.S.

CAPTAIN, DENTAL CORPS, U.S.A.

HONOLULU

THE IMPORTANCE of infection of the teeth and gums in the production of systemic infection has long been appreciated. However, there is still confusion concerning the best way to prevent such post-extraction complications as subacute bacterial endocarditis, abscess formation, iritis, or arthritis.

## Materials and Procedures

Clinical material for this investigation was obtained from 70 patients in the dental out-patient clinic of the United States Army's Tripler Army Hospital in Honolulu, Hawaii. Patients were taken at random during a period of six months. Written permission was obtained from each patient in order to include him in this special and unofficial research problem. The 70 patients were divided into a group of 35 control subjects (Group I) and a group of 35 individuals (Group II) who were treated with an aqueous suspension of procaine penicillin G. The complete control group of 35 patients was studied first; this avoided any confusion that might result from studying patients in both groups simultaneously. Patients were taken in groups of five per day.

The patients in the control group ranged in age from 18 to 42, the average being 23.9 years. The patients in the premedicated group ranged in age from 17 to 47 years, the average being about 23 years.

The patients' gums were graded on the basis of the severity of the gingival disease, with three classes of periodontoclasia recognized: these were called, in accord with commendations of the Eighth International Dental Congress, Classes I, II and III<sup>1</sup>. In Class I there was no apparent gingival disease; in Class II, there was mild to moderate disease; and in Class III, there was severe disease.

A brief case history was taken of each patient. In some instances the blood pressure was recorded and the heart and lungs were examined.

The number of extractions in the control group ranged from 1 to 7 teeth, and in the penicillin-treated group from 1 to 3. An average of 1.74 teeth was removed from the patients in the control group, and of 1.28 teeth from the group given penicillin. The usual method of extraction was employed, with the elevator and forceps technic.

All of the patients received local anesthesia with approximately 2.5 ml. of a 2% solution of procaine hydrochloride (without epinephrine). Anesthesia was induced either by conduction or by infiltration, depending on the location of the teeth. Procaine without epinephrine was used so that it would not interfere with the dispersal of the organisms from the gingival trough<sup>2</sup>.

The pre-medicated patients were given 300,000 units of penicillin in aqueous suspension intramuscularly (never intravenously) into the deltoid muscle, forty-five minutes before extraction.

The blood was withdrawn from each patient at the following intervals: (a) immediately prior to extraction, (b) immediately after extraction, (c) five minutes after extraction. Because it was necessary to withdraw varying amounts of blood from patients in Groups I and II, it was found convenient to devise the following plan:

10 ml. of blood were drawn for samples (a) and (c) from all patients.

11 ml. for sample (b) for patients in Group I.

17 ml. for sample (b) from patients of Group II in order to obtain sufficient blood for penicillin level determination. The blood was withdrawn from the median basilic vein in the antecubital space of either arm, through a 22 gauge needle, into a sterile 20 ml. syringe. From each of the blood samples (a), (b), and (c) 10 ml. portions were divided equally between two 100 ml. test tubes each containing 50 ml. of fluid thioglycollate medium. (The fluid thioglycollate medium in these large tubes was fortified with 0.033 per cent sodium polyanetholsulfonate or "liquoid",<sup>3</sup> in order to neutralize antibacterial action of whole blood.) Fluid thioglycollate was used to grow both



DR. FANNING

<sup>1</sup>Preparation used throughout the study was Crysticillin (Squibb), an aqueous suspension of 300,000 units of procaine penicillin G per cc.

<sup>2</sup>Submitted to the University of Hawaii in partial fulfillment of the requirements for the degree of Master of Science.

<sup>3</sup>Eighth International Dental Congress, Paris, 1931, Sect. 4.

<sup>4</sup>Burket, L., and Burn, C. G.: Bacteremias Following Dental Extraction. Demonstration of Source of Bacteria by Means of a Non-Patogen (*Serratia Marcescens*), J. Dent. Research 16:521, 1937.

the aerobic and anaerobic organisms. The cultures were incubated at 37°C. and were examined at twenty-four-hour intervals for seven days. Only cultures that became cloudy, showed change in color or an odor, or otherwise appeared to give evidence of growth were opened before the seventh day. All culture tubes were opened at the end of seven days. At that time, smears were made and were stained with Gram's stain. Blood agar plates were streaked and incubated under aerobic and anaerobic conditions.<sup>4</sup> All suspect cultures in the original thioglycollate medium were subcultured before being discarded.

The subcultures were made in 0.1 per cent glucose broth and on blood agar plates; these subcultures were incubated for two days at 37°C.

"Pour plates" were prepared by adding 1 ml. of blood from sample (b) (the sample taken immediately after extraction) to 10 ml. of melted and cooled beef heart infusion agar containing sodium thioglycollate supplement. These plates were incubated at 37°C. for 7 days.

Anaerobic technics were followed according to the method of Brewer and Brown.<sup>4</sup>

The organisms in the positive cultures were isolated and subcultured according to the usual bacteriological technics and were subjected to the standard tests employed by bacteriologists to differentiate and identify them.

An assay of the amount of penicillin in the blood was carried out bacteriologically by determining the amount of blood required to inhibit the growth of a susceptible stock strain of *Staphylococcus aureus* and comparing it with the amount of penicillin—in a series of dilutions of known strength—required to produce inhibition under identical conditions.<sup>5</sup> Many methods have been employed for determining the blood levels of the different antibiotics, most of them using certain strains of staphylococci, streptococci, or other microorganisms grown in broth media.<sup>6</sup>

Sensitivity test—to measure the efficacy of varying dilutions of the penicillin against test bacteria—was made by exposing an eighteen-hour culture of a stock strain (from Tripler Army Hospital) of *Staph. aureus* to serial dilutions of penicillin.<sup>7</sup> The test was read by determining both the highest dilution of penicillin inhibiting the test organism and the highest dilution permitting growth of the test organism.

A determination of the penicillin level in the blood serum of each patient was performed at the same time as the penicillin sensitivity test. The same strain of *Staph. aureus* was used here, too, as the test organism.

Measurements of the penicillin blood levels were made in order to determine the quantity of penicillin that was effective in achieving bactericidal concentrations—and therefore prophylaxis—at the time of the dental operation.

\* Based on the technic devised by Doctor Louis L. Dienes, Massachusetts General Hospital, and used by many medical technicians.

## Results

Of the blood cultures taken prior to extraction of teeth from patients in the control group, four (or 11.4%) were positive. *Staph. albus* was recovered from three individuals, and alpha hemolytic streptococcus from one. For the group of patients given penicillin, all blood cultures taken before the extraction were negative.

Of the blood cultures taken from the control subjects immediately after the extraction, 85.7% or 30 out of 35, were positive. The organisms isolated under aerobic conditions were: *Staph. albus* (six times), *Staph. aureus* (two times), alpha hemolytic streptococcus (35 times), pneumococci, which could not be typed (five times), a hemolytic *Staph. albus* (once), and a non-hemolytic streptococcus (once). The organisms isolated in Brewer's thioglycollate medium, under anaerobic conditions, were: a gamma type of streptococcus (two times), alpha hemolytic streptococci (21

times) and *Staph. albus* (once). All specimens of blood taken from the group treated with penicillin were negative for bacteria by methods employed. These cultures were incubated under both aerobic and anaerobic conditions, as were those of the control group.

Fourteen of the 35 control subjects, or 40%, showed a positive bacteremia as indicated by the blood cultures taken five minutes after the extraction. The organisms isolated under aerobic conditions were: *Staph. albus* (seven times), *Staph. aureus* (once), and alpha hemolytic streptococci (nine times). Those isolated under anaerobic conditions<sup>4</sup> were: *Staph. albus* (four times) and an alpha hemolytic streptococci (five times). In the penicillin group, all cultures were negative, just as were the cultures taken immediately after extraction (Table 1).

TABLE 1.—Incidence of Bacteremia.

NO. OF PATIENTS	GROUP	BEFORE EXTRACTION	IMMEDIATELY AFTER EXTRACTION	5 MINUTES AFTER EXTRACTION
<i>Aerobic Cultures</i>				
35	Control I .....	4	30	14
35	Crysticillin II....	0	0	0
<i>Anaerobic Cultures</i>				
35	Control I .....	0	23	9
35	Penicillin II....	0	0	0

In comparison with the control group, the administration of penicillin 45 minutes prior to extraction produced a most significant difference in the number of positive blood specimens obtained immediately after and five minutes after the removal of the patients' teeth. These results were obtained in patients who had a blood level of penicillin ranging from 0.56 units to slightly more than 11.0 units per ml. of blood.

Although alpha hemolytic streptococci are facultative anaerobes, some of them are supposed to grow well under strict anaerobic conditions. It should be remembered however, that they are a heterogeneous group and cultural characteristics may vary widely. Hoare<sup>8</sup> suggested the use of sodium polyanetholsulfonate "Liquoid" to neutralize antibacterial action of whole blood, but mentioned that it probably would inhibit the growth of anaerobic streptococci. On no occasion in these studies was growth obtained under anaerobic conditions when the organism failed to grow aerobically; in other words, no strict anaerobes were found.

Another consideration is that in making blood cultures, only a relatively small amount of material is cultured anaerobically. Thus, under conditions in which organisms are few in number—whenever, for example, the actual count is less than one bacterium per ml. of blood—inevitably there must be a small number of positive cultures. Most of the "pour plates" were negative even when the blood culture was positive, bacteria usually could not be demonstrated in numbers greater than 1 per ml. of blood. This conclusion is substantiated by the occasional finding, in duplicate plate cultures, of one positive and one negative culture.

Occasionally fermentation tests were performed, in attempts to differentiate the alpha hemolytic type of streptococci isolated from blood cultures, but there was not sufficient time to test all of the organisms obtained. In all cases, in order to differentiate streptococci from pneumococci, the ability of the cultures to ferment inulin and their solubility in bile were determined.

In these studies the alpha hemolytic type of streptococci were recovered 71 times (Table 2). The other types of streptococci were rarely seen, the gamma, or non-hemolytic, type being recovered only three times, and the beta type was never recovered. Two other organisms found with some degree of frequency were the pneumococcus and *Staph. albus*. In all, pneumococci were recovered five times from the blood stream. They tended to be atypical, and in every case resisted typing with the type-specific sera available.

<sup>3</sup> Hoare, E. D.: Suitability of "Liquoid" for Use in Blood Culture Media with Particular Reference to Anaerobic Streptococci, *J. Path. & Bact.* 48:573 (May), 1939.

<sup>4</sup> Brewer, J. H., and Brown, J. H.: A Method for Utilizing Illuminating Gas in the Brown, Fildes and McIntosh or Other Anaerobic Jars of the Laidlaw Principle, *J. Lab. & Clin. Med.* 23:870, 1938.

<sup>5</sup> Fleming, A.: Micro-methods of Estimating Penicillin in Blood Serum and Other Body Fluids, *Lancet* 2:620 (Nov. 11), 1944.

<sup>6</sup> Cooke, J. V.: Simple Clinical Method for Assay of Penicillin in Body Fluids and for Testing of Penicillin Sensitivity of Bacteria, *J.A.M.A.* 127:445 (Feb. 24), 1945.



Staphylococci were found in cultures from 20 specimens, all of them in the control group. Seventeen were *Staph. albus*, and three were *Staph. aureus*. The coagulase test<sup>7</sup> was not used routinely on all of the staphylococci isolated, but, of the eight organisms tested, all were coagulase negative, which implies that they were probably avirulent. Only three positive cultures, all of *Staph. albus*, were found in preoperative specimens taken from patients in the control group.

Despite the fact that all patients received the same dosage of penicillin, the level of penicillin in the blood varied from a low of 0.56—2.24 to a high of 4.48—11.0 units/ml. of patient's serum.

In the series of patients only one allergy reaction was noted, and this did not give a true allergic picture. This patient had previously received penicillin in beeswax, and at that time had had a very severe reaction to the drug. When he received penicillin in the deltoid region at the time of this experiment, he felt intense pain at the area in the buttocks in which he had previously received the injection of penicillin. Because the type of penicillin used in this experiment employs a vehicle that is non-allergenic, such as water, or isotonic saline, or glucose, there is a minimum of discomfort in most recipients, inasmuch as there is no foreign-body reaction from the vehicle.

In this series of studies, blood cultures taken from patients in the control group showed that, following the extraction of teeth, organisms gained access to the circulatory system in a high percentage of persons (85.7%). No organisms could be cultivated by the methods employed from the blood of patients who had received penicillin 45 minutes prior to the extraction.

ket<sup>9</sup>, in post-mortem studies of the periapical tissues of teeth and of the blood stream, showed staphylococci to be present in 48% of their positive cultures, while the same organisms were obtained in 42% of cultures taken from the blood stream at the same time. This work indicates that the staphylococci cannot be considered to be contaminants but should be considered as inhabitants of the oral cavity that gain access to the circulatory system.

It is surprising that more organisms are not found in the blood stream following dental operations. The reason that they are not found is due to the difficulty of isolating the organisms circulating in the blood stream. Culture technics must be of unusual sensitivity, since the offending organisms are usually few in number. In the series of studies reported in this paper, a "pour plate" was prepared with the blood specimens drawn from patients in the control group. These plate cultures were mostly negative, although the fluid thioglycollate cultures were positive, which indicates that the number of organisms cultivatable was less than one per ml. of blood. Thus, unless bacteria are given every chance to grow by the most sensitive methods of blood culture, negative results can be obtained. It is my belief that the low percentage of positive cultures obtained by many workers can be ascribed to their failure to use a sufficiently sensitive technic.

TABLE 2.—Organisms Recovered.

	BEFORE EXTRACTION		IMMEDIATELY AFTER EXTRACTION		5 MINUTES AFTER EXTRACTION		TOTAL
	<i>Aerobic</i>	<i>Anaerobic</i>	<i>Aerobic</i>	<i>Anaerobic</i>	<i>Aerobic</i>	<i>Anaerobic</i>	
CONTROL GROUP I							
Alpha Hemolytic Streptococcus.....	1	0	35	21	9	5	71
Staphylococcus Albus.....	3	0	6	1	7	4	21
Pneumococcus.....	0	0	5	0	0	0	5
Non-Hemolytic Streptococcus.....	0	0	1	2	0	0	3
Staphylococcus Aureus.....	0	0	2	0	1	0	3
Hemolytic Staphylococcus Albus.....	0	0	1	0	0	0	1
TOTAL.....	4	0	50	24	17	9	104
CRYSTICILLIN-TREATED GROUP II.....	0	0	0	0	0	0	0

### Comments

The occasional isolation of staphylococci, diphtheroids, and spore-bearing anaerobic bacilli—organisms commonly found on the surface of the skin—from blood samples by other workers is considered by many investigators to be evidence of the presence of contaminants<sup>8</sup>. Burn and Bur-

Pressman and Bender<sup>10</sup> studied the effect of sulfanilamide on the transient bacteremia following the extraction of teeth. Although earlier work had demonstrated that para-aminobenzoic acid present in a culture media exerts an inhibitory effect on sulfanilamide, Pressman and Bender decided

<sup>7</sup> Fairbrother, R. W.: Coagulase Production as a Criterion for the Classification of Staphylococci. *J. Path. & Bact.* 50:83, 1940.

<sup>8</sup> Elliott, S. D.: Bacteremia and Oral Sepsis. *Proc. Roy. Soc. Med.* 32:747 (May), 1939.

<sup>9</sup> Burn, C. G., and Burket, L. W.: Comparative Bacteriologic Studies of Human Blood, Viscera and Teeth Obtained at Necropsies. *Arch. Path.* 25:643 (May), 1938.

<sup>10</sup> Pressman, R. S., and Bender, I. B.: The Effect of Sulfanilamide on Transient Bacteremias Following Extraction of Teeth. I. Sulfanilamide. *Arch. Int. Med.* 74:346 (Nov.), 1944.

not to add para-aminobenzoic acid to their culture media when sulfanilamide was present in the specimens being cultured. They felt that it would interfere with their investigation in that *in vivo* conditions would not be duplicated.

Likewise, it has been shown by Abraham and Chain<sup>11</sup> that an enzymatic inactivator, *penicillinase*, has an inhibitory effect on penicillin. Sodium thioglycollate resembles penicillinase in that it, too, inhibits the action of penicillin. In my own studies reported in this paper, fluid thioglycollate medium was used as the initial medium for the cultivation of organisms that might have been present in the blood. It is true that, by using thioglycollate medium, the effect of penicillin was counterbalanced when the blood specimen was added to the medium—and therefore, any organisms present in the blood specimen were no longer submitted to the same conditions in the medium as they would have been *in vivo*—but it was my intention to determine by this means whether or not the penicillin present in the blood stream had achieved a bactericidal or a bacteriostatic effect.

Eagle and Musselman<sup>12</sup> pointed out that at low levels in the blood serum penicillin is bacteriostatic and that at higher levels it is bactericidal. For susceptible bacteria there is a minimum concentration that retards growth, a somewhat higher concentration that kills the organisms faster than they multiply, and a still higher concentration that kills at a maximum rate. In my studies, blood cultures from the patients in the control group showed that the organisms gained access to the circulation. The important question is whether or not the organisms were killed once they were present in the blood stream.

There is a considerable difference of opinion regarding the therapeutic efficacy of bactericidal concentrations of penicillin maintained for a brief time as opposed to the efficacy of bacteriostatic concentrations maintained for prolonged periods. It is not within the province of this paper to discuss the relative merits of these two approaches to penicillin therapy. Suffice it to say that there are authoritative proponents of both methods of treatment.

When one considers the myriad organisms that inhabit the mouth and the ease with which they can enter the circulation, it is surprising to find that cultures are not uniformly positive after extractions. This fact may be ascribed in part to the efficient clearing mechanism that exists within

the body and also to the sampling errors involved in culturing whole blood.

An example of the speed of the clearing mechanism is shown in the control group of patients in my series, 85.7% of whose cultures were positive immediately after extraction. In five minutes only 40% were still positive, a decrease of 45.7%. No cultures were taken after the five minute interval, for it has been shown by another investigator<sup>9</sup> that, between ten and thirty minutes after extraction, only an occasional culture will remain positive.

The mode of action of penicillin, in terms of cellular metabolism, is unknown, and much less progress has been made in this respect than was made with the sulfonamides. The structure of penicillin affords no hint of the metabolic locus upon which it acts, nor have any specific antagonists for it been discovered. Whether it competes with an essential metabolite remains to be seen, but, in any case, the evidence is unequivocal in pointing to a locus of action which is associated intimately with those processes concerned with the growth of the cell. In this respect, penicillin aligns itself with the sulfonamides in contrast with the classical disinfectants. The action of penicillin, however, is very different from that of the sulfonamides in that it acts more quickly and is much more bactericidal. At the usual therapeutic levels the sulfonamides probably exert no more than a bacteriostatic action, except perhaps in the urine. Rake et al.<sup>13</sup> reported that penicillin, on the other hand, attains levels in the body which are bactericidal for an appreciable number of invading organisms and are bacteriostatic for the rest.

Penicillin in aqueous suspension generally provides higher and more prolonged blood levels than penicillin in oil and wax, and blood levels equal to, or higher than, those produced with procaine penicillin G in oil. According to Squibb, one injection of 300,000 units of Crysticillin produces therapeutic serum levels of penicillin for 24 hours in the majority of patients, and for 36 hours in approximately 50% of patients. With the drug used, prolonged penicillin blood levels are attributed to the low water-solubility of the procaine penicillin G. In contradistinction to this, other prolonged-action penicillin preparations depend upon oil, wax, or vasoconstrictors for maintaining relatively high blood levels.

Recently there have been reports suggesting premedication with penicillin when extractions of teeth were contemplated, but in all cases the

<sup>11</sup> Abraham, E. P., and Chain, E.: Enzyme from Bacteria Able to Destroy Penicillin, *Nature*, London, 146:837 (Dec. 28), 1940.

<sup>12</sup> Eagle, H., and Musselman, A. D.: Rates at which Different Concentrations of Penicillin G Kill a strain of B-Hemolytic *Streptococcus* in Vitro, *J. Exp. Med.* 88:99 (July), 1948.

<sup>13</sup> Rake, G.; McKee, C. M.; Hamre, D. M., and Houck, G. L.: Studies on Penicillin. II. Observation on Therapeutic Activity and Toxicity, *J. Immunol.* 48:271 (May), 1944.



reliability of the results has been lessened by the low percentage of positive control cultures.

### Conclusions

Experience with this series of patients indicates that the following regime is advisable in cases of teeth extractions if the incidence of bacteremia and its subsequent complications is to be reduced.

1. Patients known to have a rheumatic heart condition or heart disease should be informed of the complications that may follow dental extractions. It might be well further to advise such individuals as to the necessity of both medical and dental supervision during all such contemplated dental operations. Dentists, especially exodontists, should always be careful to elicit a thorough history for rheumatic fever, chorea, scarlet fever, pains in joints, "growing pains", frequent sore throats, or any manifestation of the rheumatic diathesis. I believe that it cannot be too strongly stressed that such patients should be seen by a physician in consultation with the dentist.

2. Procaine hydrochloride with epinephrine hydrochloride is the anesthetic of choice. It should be employed by the infiltration or conduction method. Burket and Burn<sup>2</sup> found that there was a difference between anesthesia by conduction and anesthesia by infiltration in their effect upon bacteremia, both with epinephrine, because epinephrine constricted the capillaries and thus prevented the organisms from gaining access to the blood stream. In my own studies no differences could be demonstrated between infiltration and conduction methods. However, it must be emphasized that procaine hydrochloride without epinephrine was used in this experiment in order to permit organisms every opportunity for entering the blood stream. Conduction anesthesia can be considered to have the same effect as general anesthesia since the injection is given distant to the field of operation.

3. Only one to two teeth should be removed at a time, and these with a minimum of rocking and trauma. Full mouth extractions are to be condemned. Any manipulative procedure involving either the gums or the teeth is to be avoided, especially in patients known to have rheumatic heart disease.

4. Penicillin should be administered one hour prior to extraction. It is probable that it will not be necessary to administer the drug subsequent to extraction, in view of the observations made during these investigations. If penicillin is given, enough of the drug should be supplied to obtain

a blood level of over .156 units per ml. of serum. In this experiment 300,000 units of penicillin were administered 45 minutes before extraction. In so doing, patients were not required to wait in the clinic for long periods of time, nor were they inconvenienced by being made to appear for the penicillin injection and then return several hours later for the extractions. Furthermore, an optimum concentration of penicillin was obtained at the time of the extraction and, according to Squibb, presumably was maintained for a period of twenty-four hours thereafter.

### Summary

Patients premedicated with penicillin 45 minutes before dental extraction showed no transient bacteremia following the extraction of teeth. Those in the untreated control group exhibited positive bacteremias in 85.7% of the cases immediately after extraction and in 40% of the cases five minutes after extractions.

The organisms isolated from the blood cultures taken from patients of the control group prior to extraction were *Staphylococcus albus* and alpha hemolytic streptococci. In the group treated with penicillin, all blood cultures were negative.

The organisms isolated under aerobic conditions from the blood cultures taken from patients in the control group immediately after extractions were: *Staphylococcus albus*, *Staphylococcus aureus*, alpha hemolytic streptococci, pneumococci, a hemolytic *Staphylococcus albus*, and a non-hemolytic streptococcus. The organisms isolated from these same blood cultures under anaerobic conditions, were: Gamma streptococci, alpha hemolytic streptococci, and *Staphylococcus albus*. All of the blood cultures taken from the group treated with penicillin were negative for bacteria.

Of the blood cultures taken from patients in the control group five minutes after extraction, the organisms isolated under aerobic conditions were: *Staphylococcus albus*, *Staphylococcus aureus*, and alpha hemolytic streptococci. Those isolated under anaerobic conditions were: *Staphylococcus albus* and alpha hemolytic streptococci. In the group treated with penicillin, all blood cultures were negative.

It is recommended that all patients should receive 300,000 units of penicillin 45 minutes prior to tooth extractions. Those patients known to have a rheumatic heart condition or heart disease should especially be administered this dosage of penicillin 45 minutes prior to extraction of teeth.

# Report of Hawaii Cancer Society Cytology Laboratory

F. C. SPENCER, M.D., I. L. TILDEN, M.D.,  
and W. B. QUISENBERRY, M.D.  
HONOLULU

THIS REPORT covers the work of the Cytology Laboratory of the Hawaii Cancer Society during the period from July 25, 1949, to December 31, 1950, or approximately the first eighteen months of operation.

## History

Early in the discussion on the establishment of a Cytology Laboratory by the Hawaii Cancer Society, the authors felt that it was fundamental to have a properly trained technician for staining and screening the slides. Accordingly, Mrs. Esther Chinn was sent to the laboratory of Dr. Herbert F. Traut in the University of California Hospital where she received intensive training in this special laboratory procedure. Two of the authors also received special training in cytology in Dr. Traut's laboratory, and the third author received special training elsewhere.

Categories covering the reporting on cytology specimens submitted to the laboratory are shown in Table 1.

TABLE 1.—Categories in Which Smears Were Reported

1. Negative
2. Atypical cells present, probably benign
3. Atypical cells present, suspicious of malignancy
4. Cells present consistent with malignancy

The number of physicians using the service, the types of specimens examined, and the source of materials are shown in Tables 2 and 3.

TABLE 2.—Number of Doctors Using Cytology Service.

1. Honolulu .....	109
2. Rural Oahu .....	16
3. Hawaii .....	33
4. Maui .....	19
5. Kauai .....	11
6. Molokai .....	3
7. Lanai .....	3
TOTAL .....	194

Read before the Sixty-first Annual Meeting of the Hawaii Territorial Medical Association, Honolulu, May 5, 1951.



DR. SPENCER

TABLE 3.—Type of Smear, Number of Patients, Number of Slides Examined, and Number Positive.

TYPE OF SMEAR	PATIENTS	SLIDES	POSITIVE
Sputum and Bronchial.....	141	463	1
Gastric .....	105	237	—
Breast Secretion .....	36	66	1
Prostate and Urine.....	70	125	1
Pleural & Ascitic Fluid....	21	60	3
Oral and Nasal.....	22	42	—
Miscellaneous .....	42	82	3
SUB-TOTAL .....	437	1,075	9
Vaginal and Cervical.....	2,805	5,150	32
TOTAL .....	3,242	6,225	41

The results of the examination of specimens from the vagina or cervix, together with the number of positive or suspicious smears, proven cancer cases, etc., are shown in Table 4.

TABLE 4.—Follow-up Study of Patients with Positive Vaginal and/or Cervical Smears.

Number of patients with smears suspicious of or consistent with cancer.....	32
Number of patients with proven cancer.....	26
Number of patients with cancer not proven.....	4
Number of patients who probably had no cancer.....	2

Clinical data on stage of disease, treatment, and present status of patients appear in Tables 5 and 6.

TABLE 5.—Analysis of Patients with Clinically Suspected Cancer.

Number of Patients—16				Average Age—54		
GRADE	PATIENTS	STAGE	PATIENTS	TREATMENT	PRESENT STATUS	
I .....	1	I	6	All treated with radium or x-ray except one.	Well .....	7
II .....	1	II	3		Improved ..	2
III .....	3	III	6		Poor .....	3
II or III.....	4	IV	1		Dead .....	4
Not determined....	7					
TOTALS	16		16			16

TABLE 6.—Analysis of Patients with Clinically Unsuspected Cancer.

Number of Patients—10				Average Age—40	
GRADE	PATIENTS	STAGE	PATIENTS	TREATMENT	PRESENT STATUS
IN SITU	7	O	7	Irradiation .....	4
I	0	I	3	Hysterectomy .....	5
II	2	II	0	Sturmdorf .....	1
II or III	1	III	0		Clinically all well.
IV	0	IV	0		
TOTALS	10		10		10



### Recapitulation on Gynecologic Smears

Five thousand one hundred and fifty smears from the cervix or vagina or both, from 2,805 patients, were examined by the Cytology Laboratory of the Hawaii Cancer Society during its first eighteen months of operation. Thirty-two of these patients, or 1.14% of the total, exhibited cells on their smears which were either highly suspicious or consistent with carcinoma. Of the 32 positive or suspicious cases, 26 have been proven to have carcinoma, 22 by tissue examination and 4 by clinical course.

### Indeterminate Cases

Four cases thus far have not been proven to have cancer, but cancer has not yet been definitely ruled out. In one case, the uterus was removed, and the tissue examination said to be negative; but we have been unable to locate this material, and, therefore, do not know whether or not the pathologic study was adequate. In the second case, the patient had one biopsy which did not show carcinoma, but she has not returned for further pathologic study or cytology tests. The third patient has refused thus far to have a biopsy performed. The fourth patient in this group has had a biopsy and a dilatation and curettage which was negative. Further observation of this patient will be necessary.

### Probably Not Cancer

Two patients with suspicious smears thus far have been proven by reasonably careful pathologic study and subsequent course to probably have had

no carcinoma. The first patient has had a biopsy and a dilatation and curettage which failed to reveal cancer, and has subsequently had repeated cytologic examinations which have been negative for cancer cells. The second patient had a curettage and multiple biopsies which failed to reveal cancer. The cervix was cauterized following the biopsies; and since the cauterization, all cytologic tests have been negative.

### Smears Other Than Vaginal or Cervical

One thousand and seventy-five smears from parts of the body other than the female genital system were examined from 437 patients. Nine of these patients had smears which contained cells thought to be either highly suspicious or consistent with malignancy. Of the 9 suspicious and positive smears from body secretions other than the female genital system, all were proven to have carcinoma except one. A patient with a lung lesion and pleural effusion from which pleural fluid was examined has had a careful workup and a clinical course which seem to rule out a malignant lesion.

### Conclusion

Even though the total number of specimens examined in the laboratory to date and the number of suspicious cases found has been relatively small, it is believed by the authors that the laboratory has assisted physicians in making early diagnoses on their cancer cases and should contribute to the saving of lives.

305 Royal Hawaiian Avenue.



## UNSCENTED COSMETICS

### FOR THE ALLERGIC PATIENT

AR-EX Cosmetics are the only complete line of unscented cosmetics regularly stocked by pharmacies. To be certain that your perfume sensitive patients do not get scented cosmetics, prescribe AR-EX Unscented Cosmetics. SEND FOR FREE FORMULARY.



### FREE FORMULARY

DR. \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_

AR-EX COSMETICS, INC.,

1036 W. VAN BUREN ST.,

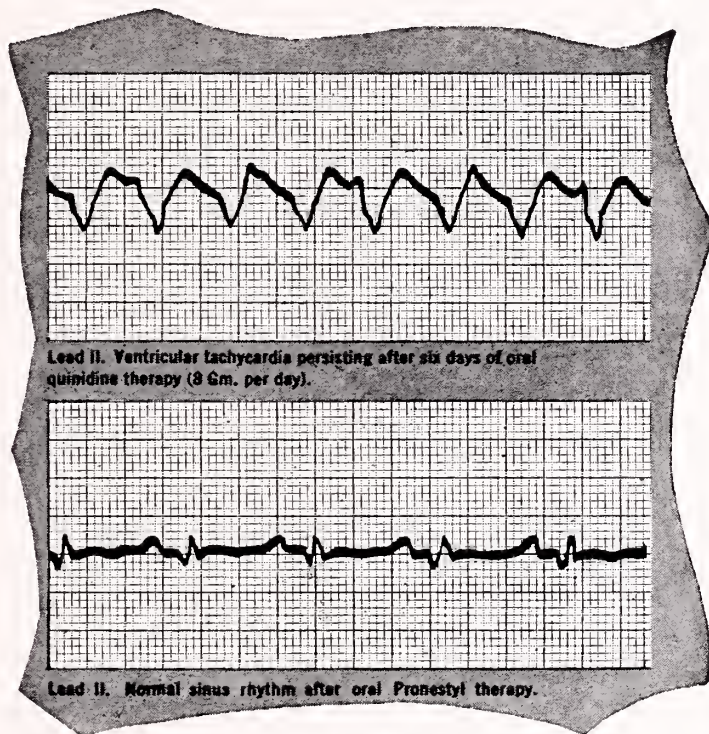
CHICAGO 7, ILL.

a **new** drug . . .

*for the treatment of ventricular arrhythmias*

# PRONESTYL *Hydrochloride*

*Squibb Procaine Amide Hydrochloride*



Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evidenced by studies of blood count, urine, liver function, blood pressure, and electrocardiogram. Pronestyl may be given intravenously with relative safety.

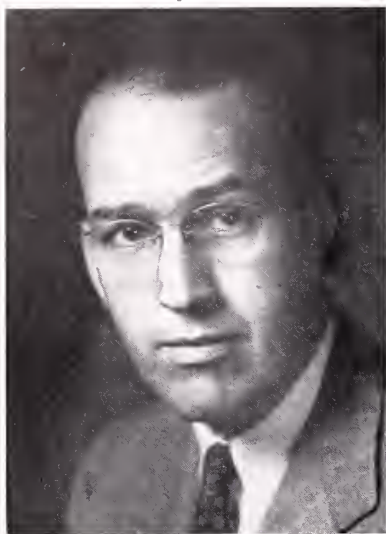
PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.  
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

*For detailed information on dosage and administration, write for literature or ask your Squibb Professional Service Representative.*

**SQUIBB** MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.





## *The President's Page*

Doctor, don't let your A.M.A. membership lapse!

It is your decision to make; you aren't compelled to be a member of the A.M.A. unless you want to par-

ticipate in its scientific sessions, or to be an officer of it, or to be—or to vote for—a delegate to it. No hospital in Hawaii has a "closed shop" restriction requiring its staff members to belong to the A.M.A.

But Doctor, you and your colleagues *are* the A.M.A.! In our unity there is strength and the power of accomplishment. Your membership entitles you—indeed, it obligates you—to press for correction of any practices of which you may disapprove. Don't just turn your back on your fellow physicians because you may not like something the top brass has been up to.

Moreover, reinstatement of your lapsed membership requires you to pay up all back dues, so that it gets more expensive each year.

So please maintain—or reinstate, if it has lapsed—your membership in *your* American Medical Association. It needs you; and you—though you might not realize it—need it.

*Henry Plummer*

# Hawaii MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D. Editor  
MRS. EDITH C. BENNETT Managing Editor  
LAURENCE M. WIIG, M.D. News Editor  
HASTINGS H. WALKER, M.D. Advisory Board  
HOMER IZUMI, M.D. Advisory Board  
PETE OKUMOTO, M.D. Associate Editor, Hawaii  
EDWARD S. KUSHI, M.D. Associate Editor, Kauai  
C. H. ISHII, M.D. Associate Editor, Maui

## [ EDITORIALS ]

### PAN-PACIFIC SURGICAL CONGRESS — 1951

The Fifth Congress of the Pan-Pacific Surgical Association will meet in Honolulu November 7-19, 1951.

All countries bordering on the Pacific Ocean are cordially invited to send representatives to this meeting, where they will meet and become acquainted with prominent surgeons from many Pacific countries.

All surgical specialty sections will be represented on the scientific program. Breakfast round table discussions will be held daily and motion pictures on surgical subjects shown.

If interested in displaying a scientific exhibit, contact Dr. J. Warren White.

### GIVE TO THE A.M.A. EDUCATIONAL FOUNDATION!

Did you ever stop to think that you didn't pay for your medical education? You paid your annual tuition, but this by no means covered the entire cost. The rest of it was defrayed by either taxes or endowments.

Most medical schools now are hard up, and could use a little repayment on that long-standing debt. The Federal Government would like to hand them some of your tax money—and with it, naturally, some instructions about running the schools. What they subsidize, they may control: so says the Supreme Court.

If the Federal Government does this, it will forthwith cry for more tax money, being able to demonstrate a new need. And medical schools will have less freedom of operation.

Many doctors, here as on the mainland, have been sending donations to their own schools for years. This is praiseworthy, but not as effective as a united program of financial support can be. So write out a check now and send it to the AMA Educational Foundation. It's not just a duty—it's a privilege, too.

### ACTH & CORTISONE MAY BE BAD FOR TUBERCULOSIS

The American Trudeau Society of the National Tuberculosis Association has recently issued the following statement regarding the use of ACTH and cortisone in the treatment of patients with tuberculosis.

"Because the action of ACTH and cortisone upon the factors of resistance to tuberculosis has been shown to be deleterious in at least three species of experimental animals and there is strongly suggestive evidence along the same lines in human beings, it is recommended that these substances *not* be used in patients with active tuberculosis, and that they be used with extreme caution in human beings with possibly latent tuberculous infection, until further investigative work has shown that such administration may be safe. The routine diagnostic examination for tuberculosis of patients under physicians' care is especially necessary for patients who are being considered for ACTH or cortisone therapy."

ROBERT H. MARKS, M.D.



### WHAT'S IN A NAME?

Perhaps some others have been as bewildered as I by the ever growing number of new names attached to new or old drugs and combinations of drugs. One hesitates a bit to order "Dodex" for a patient to take internally—sounds a bit like "Iodex"; it might, of course, be an estrogen, a sedative, or even a renal antiseptic. Actually it's only a vitamin. What do you think "Obtron" is? No—you're wrong. It's another vitamin.

There seems to be little if any effort to ease the doctor's lot by inventing informative names, and similar names for drugs with similar actions. For example, "Roniocol," "Priscoline," "Dio-  
loxol," and "Oranixon." Aside from the fact that each name has at least one "i" and one "o," I defy anyone to point out a common denominator among them.

How many of the following 10 drugs, selected at random from my own collection, can you identify by their use? The answers are upside down, so you can check yourself.

1. Aerolin	For asthma
2. Banthine	For ulcers (atropine effect)
3. Beplete	Vitamin B plus phenobarbital
4. Butisol	Sedative
5. Dexamyl	For "pure mood effect"
6. Ipesandrine	For cough
7. Liqueamin	Anticoagulant (heparin)
8. Perozil	Antistaminic
9. Stolimn	Liver and B <sub>12</sub> combination
10. Tersovin	For infected sinuses

Thirty per cent is about par for the course.

It seems to me the AMA's Council on Pharmacy and Chemistry ought to try to get drug manufacturers to use more informative, simpler, and more nearly uniform nomenclature. The present trend seems headed toward chaos—if it hasn't already arrived!

W. B. HERTER, M.D.

### ANTIBIOTICS DON'T HELP ZOSTER—YET

Chloromycetin and aureomycin, in doses as large as 2 and 4 grams daily respectively, have no effect on herpes zoster—except to reduce the incidence of secondary infection in the skin lesions. Pain and paresthesias stop no sooner, new lesions develop no less easily, and the course is no shorter or milder, in treated cases than in untreated controls.

These are the conclusions of Dr. A. Barham Carter of the Ashford Hospital in Middlesex, England, as reported in the *British Medical Journal* last May<sup>1</sup>. Eleven cases were treated for 6 days each with aureomycin, 0.5 gram 4 times a day; 11 with aureomycin, 1.0 gram 4 times a

day; 11 with chloromycetin, 0.5 gram 4 times a day; and 11 with placebo capsules containing only glucose.

The course of the patients in each group was almost uniform in respect to the need for analgesic medication, the duration of the rash, the appearance of new vesicles, and the persistence of the pain and paresthesia. Two patients improved dramatically—one a treated case, the other a control!

Secondary infection was not encountered in the treated group, and occurred in every control case; but as only talc powder was employed externally, this does not seem an adequate reason for using this expensive and potentially dangerous treatment.

H.L.A.

### SULFONE TREATMENT OF LEPROSY

R. G. Cochrane, formerly of Madras and currently Secretary of the British Empire Leprosy Relief Association in London, has recently reviewed the current status of sulfone therapy in leprosy.<sup>1</sup>

Starting with the parent drug, diamino-diphenyl sulfone (DDS) in 1937, and progressing through a series of disubstituted derivatives (promin, sulphetrone and diasone) and monosubstituted derivatives (promizole, promacatin, and sulphone Cilag), all of which were less toxic and less effective weight for weight than the original DDS, we have now come full circle to the point of using the original substance in smaller doses.

It is fascinating to note that this is almost an exact recapitulation of the history of chemotherapy of syphilis: Ehrlich early tried using arsenoxide, which was effective but highly toxic, and went on through a series of combined and substituted compounds up to No. 606 (arsphenamine) and No. 914 (neoarsphenamine). Then there was, around 1935 to 1940, a general shift back to oxyphenarsine hydrochloride or arsenoxide (Mapharsen), which was, like DDS, effective in relatively minute doses as compared with its more complex derivatives.

If we extrapolate our comparison, we may anticipate that in leprosy, as in syphilis, we will presently be using an antibiotic instead of an artificial chemical, and obtaining vastly superior results from our treatment. This is something to look forward to; for although lepromatous leprosy can be controlled by present methods, it takes over 7 years, on the average, to render half the cases bacteriologically negative, and even then some will relapse. Only by early diagnosis can we prevent this protracted period of isolation and treatment.

H.L.A.

<sup>1</sup> Carter, A. B.: Investigation Into the Effects of Aureomycin and Chloramphenicol in Herpes Zoster, *Brit. Med. J.* 4713:987 (May 5), 1951.

<sup>1</sup> Cochrane, R. G.: Chemotherapy in Leprosy, *The Practitioner* 166:373 (April), 1951.

# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## REPORT OF THE A.M.A. DELEGATE, ANNUAL SESSION, JUNE 11-15, 1951

Your delegate and alternate, Dr. Homer Izumi, did our best to cover the multitudinous affairs of both the House of Delegates and Scientific Session, during the annual session. At the outset I should like to commend Dr. Izumi for his work and his interest. Prior to my arrival, Dr. Izumi had attended the Conference of Presidents and had made himself heard with credit to himself and the Territory at committee meetings.

**Monday:** After registrations for the House of Delegates, the meeting was called to order and all but a handful of the 198 delegates were present at roll call. Dr. Allen O. Whipple of New York was chosen the recipient of the Distinguished Service Award for 1951. Dr. Elmer Henderson summarized the work of the year with special emphasis on the Public Relations program, the Medical Education Foundation and the Student American Medical Association. During that afternoon, many resolutions were introduced.

There are 14 standing committees, of 5 delegates each, and it is before these committees that the arguments, pro and con, regarding resolutions are heard. The committees make up their reports and submit them to the House of Delegates, which may either accept, reject or further debate the matter. Your delegate found himself appointed a member of the Committee on Miscellaneous Business. Fourteen matters were referred to this committee.

That evening a banquet was held for the delegates by the Medical Society of New Jersey at which we were addressed by Mr. Dave Beck, Executive Vice-President of the International Brotherhood of Teamsters of the A. F. of L. In an extremely forceful manner, he rejected Government-controlled medicine and stated the answer lies in improving our voluntary prepaid medical plans. His talk was given on a nationwide broadcast. After the formal address was over, he returned to the microphone and informally restated his position. For this he received a standing ovation from the House of Delegates.

**Tuesday:** The better part of ten hours the next day was spent by your delegate in the Committee on Miscellaneous Business. A few of the matters referred to this committee are worth mentioning. Dr. McKittrick of Massachusetts introduced a resolution regarding the advisability of making space available in the A.M.A. Journal to members of the A.M.A. on both sides of any controversial issue. This was approved by the committee. There were two resolutions regarding the payment of dues. It was decided not to forgive the 1950 dues. The entire subject of dues was referred to the Board of Trustees for further study largely because it was felt that some constituents needed further time to clarify the issue among their members. There were two resolutions regarding the propriety of certain advertising material and it was felt that commercial organizations should receive advice from the A.M.A. before putting out advertising on medical matters. A new Reference Committee on Nervous and Mental Diseases

was approved. The subject of medical ethics, particularly as regards doctors' selling drugs, was subject to prolonged and heated debate. As there are many places in the United States where this is done, an attempt was made to re-write this section of the principles of medical ethics. The Judicial Council felt that this might let down the bars regarding appliances and instruments, including spectacles, and therefore disapproved of the re-writing of this section. The Judicial Council was supported by the House of Delegates after some debate. A resolution introduced by the Judicial Council suggesting that the House of Delegates reverse its position of 1950 wherein it had stated that it was ethical for a physician to address lay groups (particularly optometrists) on the subject of diseases of the eye was also debated at some length. The committee felt that this should be permitted and the House of Delegates concurred. On Tuesday evening, a formal meeting of the House of Delegates in the convention auditorium was held, at which time Dr. John W. Cline of San Francisco was installed as President of the A.M.A. for 1951-1952.

**Wednesday:** The House of Delegates met both morning and afternoon to hear the reports of the Reference Committees. Three other resolutions in addition to the ones referred to your delegate's committee, are worthy of comment. First, regarding the abolishment of the classification of Fellowships: many favored this and it was referred to the Board of Trustees for report at the interim session in Los Angeles in December. Second, the report of the Joint Commission on Accreditation of Hospitals: a tremendous amount of work by President Henderson and other officials of the American Medical Association has gone into the study of how to carry on the inspection of hospitals, which became, last year, too costly for the American College of Surgeons. A joint committee from the American College of Surgeons, the American College of Physicians, the A.M.A. and the American Hospital Association has had prolonged meetings on this subject. Dr. Henderson has strenuously fought for a distribution of votes of this joint commission as follows: American College of Physicians, 3 votes; American College of Surgeons, 3 votes; American Hospital Association, 6 votes; and the A.M.A., 6 votes. A proposal was recommended whereby a non-profit corporation of these four groups would be set up in the State of Illinois which would carry out the inspection program. Further study of this plan is going forward. A third resolution, instructing the officers of the A.M.A. to renew efforts to make post-graduate education expenses income-tax-deductible, is of special interest to us in Hawaii. On Wednesday night, your delegate as a guest of Dr. Nicholson Eastman, of Baltimore, attended the Passano Foundation Award Banquet. Dr. Phillip Levine, of New Jersey, and Dr. Alexander Wiener, of Brooklyn, divided the \$5000 cash prize for their work on the Rh factor in human blood.

**Thursday:** On Thursday, Dr. Louis H. Bauer was chosen President Elect of the American Medical Association to succeed Dr. Cline and Dr. Oscar B. Hunter,



of Washington, D. C., was elected Vice-President. Following this the House of Delegates adjourned.

#### Scientific Exhibits

No one who attended the scientific exhibits could fail to be impressed with the strides scientific medicine and surgery are making. Two gold medal awards were given for cardiac surgery—one to Drs. Glover, Bailey and O'Neill, of Philadelphia; and the other to Drs. Potts, Ricker and DeBord, of Chicago. This year the entire upper floor of the convention hall was devoted to the commercial exhibits. This gave them much more room and a better chance to show their wares. Three quarters of the basement was given over to the scientific exhibits and the remainder to colored television sponsored by Smith, Kline and French. Tribute should be given to our own Ralph B. Cloward for his hard work in putting on his exhibit which received honorable mention by the Exhibits Committee on Awards.

Finally, your delegate wishes to express his gratitude to the California delegation, the Illinois delegation, the Pennsylvania and New York delegations for their hospitality at the noon hour. For years the California delegation has been outstanding in this regard, and the other large states are catching on. The aces and deuces, or the one- or two-delegate constituents, held a meeting at which they chose as officers Dr. Charles L. Farrell of Rhode Island and Dr. Jesse Hamer of Arizona, and started formulating plans for the interim session in Los Angeles.

ALFRED S. HARTWELL, M.D.  
*Delegate to the A.M.A.*

#### SUPPLEMENT TO DELEGATE'S REPORT

Having preceded Dr. Hartwell to the Convention, I was privileged to attend a couple of meetings which are worthy of reporting briefly. The first was a meeting on Home Town Veterans Medical Care Program.

This meeting was called to discuss the program of care of veterans in various areas throughout the United States. It was pointed out that there has been a decreasing number of veterans getting private medical care and that there were Veterans Administration restrictions as to the service a private physician may give to his patient; for example, the number of office calls and types of medication.

While some areas' programs were administered through existing voluntary prepaid health organizations, similar to the program we have in the Territory with the HMSA acting as an intermediary, other areas function through their state medical societies, setting up in some instances a separate organization to handle the veterans' care program. In these instances the society employed a medical coordinator as a liaison man between the Veterans' Administration and the medical society, whose salary, paid by the medical society, was subsequently paid by the Veterans' Administration.

While there was a decline in the number of veterans getting private care, it was felt that with war casualties filling the Veterans' Administration hospitals, there would be an increasing number of veterans who would return to private physicians for follow-up care. In view of this possibility it was suggested that there be more cooperation between the Veterans' Administration and the medical societies, to expedite and correct the deficiencies as they exist in the various areas.

The next topic of interest was that of the Conference of Presidents and State Officers, held the day before the official opening of the A.M.A. This conference was held primarily to get the observations and opinions of representative small American community leaders as they see American medicine today. The community leaders who participated were a physician, an editor, a clergyman and a senator. In brief, the Conference pointed out that the American public at the grass roots level has been alerted to the potential danger of socialized medicine as the first step toward the loss of free enterprise. In general, approval was given to the more recent publicity campaign of the A.M.A. in declaring itself in league with those who fight to preserve the principles of American freedom. It was pointed out that there are imperfections yet, in that our advertising campaign and our lip service must yet be backed by action.

The communities without medical care, the need for correcting doctors whose actions and professional charges were considered so improper as to warrant their condemnation, and the need for returning to the concept of considering each patient as an individual personality, were points that were raised for correction.

The need for the professions to take a more active interest in our government and its policies was emphasized by a senator. He pointed out that to take a political stand on matters which affect only the medical profession, savors too much of a selfish interest, and the great need for more intelligent elective members in Congress could only be met by a more intelligent electorate, such as could come from the professions. He therefore pleaded that the medical profession take the lead in advocating its interest in their local communities on all political matters.

Perhaps the best example of what can be done at the home town level in answer to many of our common problems and criticisms, was evidenced in a radio broadcast over the national hook-up of the NBC just prior to the opening of the A.M.A. This broadcast, entitled "What the Doctors Ordered," brought to the American public the working of the Alameda County Medical Association. It was so well presented that a description here could not do it justice. It is heartily recommended that this transcribed record be obtained for presentation to our Medical Societies in the Territory with an idea toward the improvement of our own community service program.

HOMER M. IZUMI, M.D.  
*Alternate Delegate to the A.M.A.*

# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*  
MRS. KAY LINN, *Library Assistant*  
Phone 6-5370

8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.

Monday through Friday

Closed Saturdays at noon and Sundays

Closed all day and evening on National holidays  
and at noon on Territorial holidays

## RECENT ACQUISITIONS

### Anatomy & Physiology

- Friedman, S. M. *Visual anatomy: head and neck*. c1950. (gift of publisher)  
Gray, C. E. *Study guide textbook in anatomy and physiology*.  
Greisheimer, E. M. *Physiology and anatomy*. 6th ed. c1950. (from Nurses' Association)  
Hall, V. E., ed. *Annual review of physiology*. v.13. 1951.

### Bacteriology & Immunology

- Sherwood, N. P. *Immunology*. 3rd ed. c1951. (gift of publisher)  
Witton, C. J. *Microbiology*. c1950. (from Nurses' Association)

### Biography

- Thomson, E. H. *Harvey Cushing*. c1950. (gift of publisher)

### Cancer

- Abelmann, H. W. *Cancer as I see it*. c1951. (gift of publisher)

### Clinical Medicine

- Bray, W. E. *Clinical laboratory methods*. 4th ed. c1951. (gift of publisher)  
*Veterans Administration Technical Bulletins. Series 10*. v.4. 1951. (gift of Veterans Administration)

### Digestive System

- Bargen, J. A. *Chronic ulcerative colitis*. c1951. (gift of publisher)

### Endocrinology

- Association for Research in Nervous and Mental Diseases. *Life stress and bodily disease*. v.29. c1950.  
Selye, Hans. *Stress*. c1950.

### Geriatrics

- Shock, N. W., ed. *Conference on problems of aging*. 1951. (gift of Josiah Macy, jr. Foundation)

### Hematology

- Race, R. R. *Blood groups in man*. 1950. (gift of publisher)  
Zweifach, B. W., ed. *Factors regulating blood pressure*. 1951. (gift of Josiah Macy, jr. Foundation)

### Neurology & Psychiatry

- Abramson, H. A., ed. *Problems of consciousness*. 1951. (gift of Josiah Macy, jr. Foundation)  
Foerster, Heinz von, ed. *Cybernetics*. c1951. (gift of Josiah Macy, jr. Foundation)  
Larsell, Olof. *Anatomy of the nervous system*. 2nd ed. c1951. (gift of publisher)  
Nachmansohn, David, ed. *Nerve impulse*. c1951. (gift of Josiah Macy, jr. Foundation)  
Schwab, R. S. *Electroencephalography in clinical practice*. c1951. (gift of publisher)

### Obstetrics

- Barzilai, Gemma. *Atlas of ovarian tumors*. c1943.  
Read, G. D. *Childbirth without fear*. c1944. (gift of Dr. & Mrs. Sexton in memory of Dr. Milnor)

### Ophthalmology

- Tassman, I. S. *The eye manifestations of internal diseases*. 3rd ed. c1951. (gift of publisher)

### Orthopedics

- De Lorme, T. L. *Progressive resistance exercise*. c1951. (gift of publisher)  
Duchenne, G. D. *Physiology of motion*. c1949.  
Geschickter, C. F. *Tumors of bone*. 3rd ed. c1949.  
Girard, P. M. *The home treatment of spastic paralysis*. c1937.  
Ragan, Charles, ed. *Connective tissues*. 1951. (gift of Josiah Macy, jr. Foundation)

### Pediatrics

- De Sanctis, A. G. *Handbook of pediatric medical emergencies*. c1951. (gift of publisher)  
Senn, M. J. E., ed. *Problems of infancy and childhood*. 1951. (gift of Josiah Macy, jr. Foundation)  
Watson, E. H. *Growth and development of children*. c1951. (gift of publisher)

### Therapeutics

- Conn, H. F., ed. *Current therapy*. 1951. c1951. (gift of publisher)

### Tropical Medicine

- Manson-Bahr, Sir Philip H., ed. *Manson's tropical diseases*. 13th ed. 1950.

### Tuberculosis

- Myers, J. A. *Tuberculosis among children and adults*. 3rd ed. c1951. (gift of publisher)

### Miscellaneous

- Army Medical Library Author Catalog*. 1949.  
*Directory of Medical Specialists*. v.5. c1951.

We regret to announce that Miss Katherine Newhall is leaving the Medical Library to accept a position with the Coast & Geodetic Office in Washington, D. C. Our best wishes and aloha go with her.



## BOOK REVIEWS

### **De Re Medicina, Editio Tertia.**

643 pp. Eli Lilly and Co., Indianapolis, Indiana, 1951.  
Price: gratis.

Only in America can you get 10,000 units of penicillin for a penny, and only in America can you get a ten dollar medical textbook for nothing. This third edition of Eli Lilly's "De Re Medicina," like its predecessors, is being distributed gratis to the medical profession. Careful review shows it to be a genuinely worthwhile addition to any doctor's library. It is not just another advertising pamphlet.

In textbook fashion, each disease is discussed as to etiology, diagnosis and treatment, and Lilly products are not plugged or surreptitiously sneaked in. The writing is clear and succinct, the information reliable. Additional sections comprise a list of poisons and antidotes, various diets, pharmacological data, and a most helpful chapter on laboratory tests.

The section on psychiatry is delightful. Only 13 pages long (no verborrhea) it is a marvel of calm, clear explanation, incredibly free of Freudian gobbledygook and analytical baloney.

The colored anatomical plates, unfortunately, are neither informative nor decorative.

The book is an honest product of which Lilly can be proud. It is an unbeatable bargain—you get a real *something* for nothing this once.

C. A. DOMZALSKI, JR., M.D.

### **Chronic Ulcerative Colitis.**

By J. Arnold Bargaen, M.D., 62 pp. Price \$2.00. Charles C. Thomas, Springfield, Ill., 1951.

It is presumptuous for anyone to criticize any man's comments regarding chronic ulcerative colitis. This 60-page booklet contains the most information on etiology, pathology, diagnosis and medical treatment of the conditions to be found anywhere in one place.

Dr. Bargaen cannot refrain from inferring that a diplostreptococcus is the essential etiological agent, a concept not shared by most men with experience in treating this disease. Only minimal reference is given to the lysozyme theory and to the importance of psychosomatic factors as pathogenic possibilities. His remarks on the constitutional value of ACTH and cortisone are limited, and the possible use of vagotomy in certain cases is not included. However, in my opinion, his discussion of the indications for surgical treatment are clear and reflect sound judgment. The chapters on Pathology and the Principles of Medical Treatment are excellent, and I believe that this latter section should be considered a classical description of the disease process. Everyone should read Dr. Bargaen's discourse on this baffling disease.

V. C. WAITE, M.D.

### **Fainting.**

By George L. Engel, M.D., 140 pp. with 4 illustrations.  
Price \$2.75. Charles C. Thomas, Publisher, 1950.

This monograph presents an exhaustive study of the mechanisms and clinical characteristics of the frequently encountered but poorly understood symptom-complex of fainting. The various etiological factors are presented in a fashion which enables the reader to understand more clearly the mechanisms operating in individual cases, and differential diagnostic factors are especially clearly outlined. Types of treatment and measures for prevention of attacks are presented for the various types of causative mechanisms. The presentation of EEG and EKG tracings in cited cases adds considerably to their clarity.

This is a very comprehensive study, backed by an extensive list of references, yet very easily readable and understandable. This information is condensed in 118 pages, and particularly well worth the relatively short time required for its reading.

A. V. MOLYNEUX, M.D.

### **Eye Manifestations of Internal Diseases.**

By I. S. Tassman, M.D., 672 pp. with 279 illustrations.  
Price \$12.00. C. V. Mosby Co., 1951. 3rd edition.

This worth-while text covers the field of medical ophthalmology in a concise and comprehensive manner. It is intended not alone for the ophthalmologist but also for those engaged in the study and practice of all branches of medicine. The presence of this third edition attests to the success of the author in writing this well organized and authoritative text, and its recognition by the medical profession.

The first few chapters deal with the normal structures of the eye, examination of the patient with some of the routine tests, methods and instruments used in examination of the eyes. Then follows a discussion of the eye manifestations of most of the known structural abnormalities and diseases of all the systems of the body. Reference has been made to the standard textbooks as well as recognized ophthalmological and medical publications and many of the illustrations have been taken from these sources.

No mention is made of ACTH or cortisone but the antibiotics and sulfonamides are referred to in their proper relation to treatment. The text has many good illustrations taken from the author's service at Wills Hospital as well as from other recognized sources. Some of the black and white fundus photographs reproduced leave much to be desired in their interpretation of the pathological condition. There is an excellent index. The format is pleasing and in general the text fulfills its purpose. It is well written and edited and is a valuable addition to any medical library.

H. F. MOFFAT, M.D.

**Blood Groups in Man.**

By R. R. Race, Ph.D. (Cantab.), M.R.C.S. (England) and Ruth Sanger, Ph.D. (London), B.Sc. (Sydney), 277 pp. Price \$6.50. Charles C. Thomas, Publishers, 1951.

This book is a compendium of the present day knowledge on blood factors. It is not written for continuous reading but as a reference work. This is not to imply that it is difficult reading, it definitely is not that, but it is rather slow reading with many charts, statistics and figurative explanations. Certainly there is very little, if anything, missing on the subject of blood groups and every question which may arise in the serologist's work can probably be answered by Race & Sanger.

A great many facts have been collected by various workers in the first fifty years of this century, all the facts relating to blood groups, concerning their importance as antigens and the method of their heredity are found in this tome. It is a reference book which should be in all laboratories doing blood work, and should be available in all complete libraries, since it is of importance not only to the serologist but to the lawyer as well.

LEON E. MERMOD, M.D.

**Current Therapy 1951 — Latest Approved Methods of Treatment for the Practicing Physician.**

Edited by Howard F. Conn, M.D., 699 pp. Price \$10.00. W. B. Saunders Co., 1951.

Over 250 authorities, one or two from practically every medical school in the country and many men in private practice, contributed to make this a masterful compilation of up-to-date treatment.

Directions are most explicit: exact dosage, timing, trade names of drugs, and substitutes are all given. For important conditions the methods of two or more authors are given. Diagnosis and theory are practically absent.

It is a large hefty book, not a mere handbook, and would seem to be invaluable to anyone with an active, variegated practice. The colorful cover and easy-on-the-eyes page format make it a pleasure to read. This book has my sincerest recommendations: I bought a copy.

C. A. DOMZALSKI, JR., M.D.

**Anatomy of the Nervous System.**

By Olof Larsell, M.A., Ph.D., Sc.D., 498 pp. Price \$9.00. Appleton-Century-Crofts, Inc., N. Y., 1951. 2nd edition.

The elucidation of the form and function of the nervous system is probably as difficult a task as any. Dr. Larsell's book represents the condensation of a great amount of work into a book of usable size. The gross and microscopic features are well covered. Embryology and comparative anatomy studies are used extensively to seek to explain the adult anatomy.

The type is easy to read and the illustrations are many and excellent. The book is very much up to date with the inclusion of very recent work. Many students will miss the exclusion of illustrative lesions and clinical examples which often help to make the textbook more interesting.

JOHN J. LOWREY, M.D.

**Progressive Resistance Exercises.**

By Thomas L. Delorme, B.S., M.D., and Arthur L. Watkins, A.B., M.D., 237 pp. Price \$5.00. Appleton-Century-Crofts, Inc., 1951.

This manual by Dr. Delorme and Dr. Watkins of the Massachusetts General Hospital is very well written and illustrated. The book is written for the orthopedic surgeon and the physiotherapist, and should be of interest to all physicians using physiotherapy.

The chapter on basic physiology is well done but highly technical in sections. There are special chapters devoted to fractures, osteomyelitis, osteo-arthritis and low back pain.

The book is filled with excellent illustrations. Some of the principles illustrated can be easily applied without too much expense in the doctor's office or patient's home.

The general make-up of the book is first-class and certainly reflects credit on the authors and the publishers.

B. ALLEN RICHARDSON, M.D.

**Growth and Development of Children.**

By Ernest H. Watson, M.D., and George H. Lowrey, M.D., 251 pp. Price \$5.75. Year Book Publishers, Inc., 1951.

The authors adequately treat the subject of growth and development of children with a comprehensive review of the literature and by presenting it clearly, tersely, and interestingly. The book fills the practical need for a reference book which contains more material than the average textbook of pediatrics devotes to the subject and which correlates the seemingly unrelated nature of many individual studies.

Here is a book highly recommended for general practitioners and pediatricians who are constantly confronted with the evaluation of children in terms of growth and development in health and disease.

C. K. KOBAYASHI, M.D.

**Handbook of Medical Management.**

By Milton Chatton, A.B., M.D., Sheldon Margen, A.B., M.D., Henry D. Brainerd, A.B., M.D., 2nd Edition, 486 pp. Price \$3.00. University Medical Publishers, California, 1951.

As promised by the University Medical Publishers, the second edition has arrived one year after the first appearance of this handy little book on therapeutics. The second edition has two important additional chapters—one on fluid and electrolyte therapy and parenteral feeding, the other on hormones and hormone-like agents. The rapid strides in the use of hormones, including ACTH and cortisone, are condensed into a workable outline for the busy practitioner. Other welcome improvements are pictures and diagrams which clarify the text in many instances.

For a handy, easy to use therapy reference the Handbook of Medical Management is the answer to a physician's prayer, and it is certainly here to stay. It does not completely substitute for the larger, more detailed compendiums, but for the average physician who wants to know "what, how much, and how often" this handbook, which can be carried in a coat pocket, is highly recommended.

MORTON E. BERK, M.D.



**Electroencephalography in Clinical Practice.**

By Robert S. Schwab, M.D., 195 pp. with 106 figures. Price \$6.50. W. B. Saunders Company, 1951.

This book supplies a real need; it contains information that would enable a clinician, with little knowledge of electronics, to have a working knowledge of the electroencephalograph machine, to perform a competent routine recording, and to understand the principles of the interpretation of the records. It is written primarily for neurologists, internists, psychiatrists and neurosurgeons who have a practical interest in what electroencephalography has to offer in problems of diagnosis and treatment.

This book is therefore not a manual for the expert but rather a guide to the uses and limitations of electroencephalography in the diagnosis and study of diseases of the nervous system. The need for combining and correlating this method with other diagnostic procedures is underlined by the author. He brings into focus the major achievements of clinical electroencephalography, integrating the findings of other authorities with his own experience of more than a decade.

The book is well organized, profusely illustrated and very readable.

Y. T. WONG, M.D.

**Clinical Laboratory Methods.**

By W. E. Bray, B.A., M.D., 614 pp. with 137 illustrations. Price \$7.25. C. V. Mosby Co., 1951. 4th edition.

This book is an expansion of the previous editions. Each edition has been amended and increased as changing concepts and newer procedures have become acceptable. The preface reveals the new procedures included.

This volume is probably the simplest laboratory work which can be used by the general practitioner and even the specialist in internal medicine. It is a useful guide to the laboratory procedures aiding in diagnosis of any particular patient. It is further a rapid though by no means complete analysis for correlating inexplicable or contradictory laboratory results with the clinical condition of the patient.

The book is small and compact. However, the print is legible and the arrangement is such that reference can quickly be made to any section. The index is quite complete.

In all, this is a valuable little reference for helping in the practice of medicine; it is certainly not a technical laboratory manual.

W. HAROLD CIVIN, M.D.

**The Neuroses.**

Diagnosis and Management of Functional Disorders and Minor Psychoses. By Walter C. Alvarez, M.D., 667 pp. Price \$10.00. W. B. Saunders Co., 1951.

This book on neuroses, by Alvarez of Mayo Clinic, is an absolute must for doctors in every field of medicine who have personal contact with patients. Written in chatty, conversational style, this book is extremely easy to read. It is a distillate of the author's forty-five years of experience with nervous patients.

For those already familiar with the books and articles published by Alvarez previously on the subject, there is relatively little new working material. For those not familiar with similar publications, "The Neuroses" can be recommended without reservation.

MARQUIS E. STEVENS, M.D.

**Physiology and Anatomy.**

By Esther M. Greisheimer, B.S., M.A., Ph.D., M.D. Sixth Edition. 841 pages with 478 illustrations. Price \$4.00. J. B. Lippincott Company, Philadelphia, London and Montreal, 1950.

The general plan and purpose of this edition remains basically the same as that of previous editions in which the author attempts to "present the essentials of anatomy and present-day physiology logically, simply and graphically." Again, Dr. Greisheimer's wide classroom experience is evidenced throughout her text as she explains each topic with a scholarly thoroughness and simplicity, sacrificing neither content nor technical terminology. Most of the illustrations of the fifth edition have been retained and 15 new ones added making a total of 478 valuable visual aids to learning. They are very well distributed throughout the book and carefully and adequately labeled.

In this revision, the chapters on the physiology of the muscular, circulatory and endocrine systems have been thoroughly revised. Minor changes have been made in the chapters dealing with the special senses and the respiratory and excretory systems.

There are no questions or exercises at the close of the chapters or the units to assist the student in learning, thinking and self-evaluation. The summaries, however, are excellent and will be of assistance to the student in providing for a more comprehensive understanding of the material covered.

Apart from these weaknesses, due, no doubt to the author's insufficient familiarity with the professional curriculum in the school of nursing, the text should continue to be deservedly popular. It may certainly be unreservedly recommended as a reference which should be available in every nursing school library.

MARGARET MALLEN, R.N., B.S., M.Ed.

**Immunology.**

By Noble Pierce Sherwood, Ph.D., M.D., F.A.C.P., 731 pp. with illustrations. Price \$8.00. C. V. Mosby Co., 1951. 3rd edition.

This book, first printed in 1935, is now in its third edition. The second edition (1941) was reprinted in 1946. The present edition has been considerably enlarged and thoroughly revised, and includes many new topics, such as latent infections and mechanisms of viral infections, as well as the new concepts of the relationship, if any, of endocrines and vitamins to resistance and susceptibility.

The subject matter may be considered to embrace the logistics and tactics of the human organism in its fight for survival. It necessarily considers the enormous fields of physiology, pharmacology, organic, biological and physical chemistry, anatomy, pathology and general biology, and points out the path by which one can apply these fields in studying infection, resistance, susceptibility, and diagnostic procedures. The chapters on specificity, complement fixation and flocculation techniques and allergy are excellent.

This book can be recommended unreservedly to all physicians and medical students interested in the "why" and "how" of infection and has particular interest to bacteriologists, serologists and immunologists. I do not know where a better reference list on all phases of immunology could be found at the present time.

JAMES R. ENRIGHT, M.D.

**Cancer as I see it.**

By Henry W. Abelmann, M.D. 95 pp. Price \$2.75. Philosophical Library, Inc., 15 East 40th St., New York, 1951.

It is pointed out in this book that a number of scientific workers in the field of cancer research have believed cancer to be an infectious disease. Some good scientists are carrying on special projects in an effort to prove this hypothesis.

The ideas of this author in the field of cancer control are very good. He points out the important part which the family doctor or dentist can take in the cancer control program and thus promotes the idea of making every private physicians' or dentists' office a cancer detection center. He also urges regular physical examinations for early cancer detection.

This book is quite well written and would be suitable for members of the medical profession, especially those interested in cancer research, and, in general, is written in language which could be understood by the lay public.

WALTER B. QUISENBERRY, M.D.

**Pulmonary Ventilation and Its Physiological Regulation.**

By John S. Gray, M.D., Ph.D. 82 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

This brief monograph gives an excellent description of the physiological mechanisms governing respiration. The author shows clearly that oxygen is strongly contra-indicated in morphine and barbiturate poisonings. He then progresses into a highly technical description of the details of the mechanisms of pulmonary ventilation. This book is of considerable value for the expert in the field of respiratory physiology, but leaves the novice considerably bewildered at the complex formulas used in the calculations.

RAYMOND M. DEHAY, M.D.

**Microbiology with Applications to Nursing.**

Catherine Jones Witton, M.A., Associate Professor of Biology at Simmons College School of Nursing. 210 drawings and photomicrographs, 692 pages. Price \$4.50. McGraw-Hill Book Co., Inc., New York, N.Y., 1950.

As a text it is very modern, highly scientific, and well organized. The writing is fresh and spontaneous, clear and concise like that of a good teacher. Special emphasis is placed on physiology in microbiology. The newest aspects of the subject and many electron micrographs make other texts appear outmoded in contrast.

The photography is good. Illustrations are even better. Unfortunately color prints were not used. Every phase of the subject is well covered. Laboratory technics are clearly defined. Classifications are concise.

Most students without a thorough course in organic chemistry would find this text somewhat difficult. But every nurses' library should be plentifully supplied with reference copies of it.

B. SCHIFFMAN, R.N., B.S.

**Textbook of Medicine.**

Edited by Russell L. Cecil, M.D., Sc.D., and Robert F. Loeb, M.D., 1627 pages. Price \$12.00. W. B. Saunders Company, Philadelphia and London, 1951.

The eighth edition of this time honored textbook has had its editorial base considerably broadened by the addition of an eminent co-editor, Doctor Robert F. Loeb, Bard Professor of Medicine, Columbia University, New York, and an equally prominent associate editor, Doctor Alexander B. Gutman, Professor of Medicine, Cornell. These plus the senior editor, the two previous associate editors, Walsh McDermott and Harold G. Wolff, and 162 other contributors, constitute a most imposing array of authorities on the subject of internal medicine.

The volume is written, as before, as a series of essays on individual disease conditions, brief yet sufficiently detailed to meet the requirements of teaching or of daily practice. Emphasis has been placed on the "physiologic, biochemical and psychologic aspects of disease." While the previous classification and grouping of disease entities has been in general maintained, some reorganization of material has been achieved, i.e. infectious mononucleosis has been placed under the virus diseases, the erythemas under allergy. The diseases of collagen have been grouped together under that heading, completely rewritten and revised in the light of newer developments, with a concise clarifying introduction by George Baehr added, all in all a most valuable contribution.

Two other sections very strongly handled in this edition are the diseases of the ductless glands and the diseases of the nervous system. The former has a comprehensive introduction by Fuller Albright, the Thyroid is discussed by David Barr, the Pituitary by A. T. Kenyon and the Adrenals by George Thorn. Physiology and the newer developments are emphasized throughout. The diseases of the nervous system are covered by a much larger group of authors, yet equally well handled, a feature sometimes missing in textbooks of medicine. Even the psychosomatic aspects are well discussed, though briefly.

A notable feature is that therapy is "up to the minute." Therapeutic developments announced in late 1950 have been included; e.g., streptokinase-streptodornase is included in the management of empyema and pleural effusion. While the physiology of ACTH and cortisone is discussed in connection with their glands of origin, their use as therapeutic agents is included under the individual disease conditions. Likewise, antibiotics, including the newer useful members of the group, are handled under therapy of the individual conditions rather than as a separate topic.

Page make-up is again two columns per page. A new sharper pica type has been used which adds much to the readability.

In summary then, the eighth edition of this text maintains the high standards of past editions, and with the additions and revisions noted above, remains one of the outstanding standard reference texts on internal medicine. It is readable, brief, yet complete, one to which the student or the experienced practitioner alike can turn for quick authoritative information on subjects within the field.

CHARLES L. LEEDHAM, M.D.



### Medical Neuropathology.

By I. Mark Scheinker, M.D., 385 pp. with 186 illustrations. Price \$10.00. Charles C. Thomas, Publisher, 1951.

Dr. Scheinker's book is not one of those dry, factual, descriptive books on postmortem tissues. He presents an entirely new and different approach to neuropathology, one that will not only be of value and interest to the neurologist but will be well worth an occasional perusal by specialists in other fields and the general practitioners. You will find, in addition to the microscopic description of the lesions of the central nervous system, a comprehensive discussion of the neuroanatomy and neurophysiology of the tissues involved with case histories.

He does not attempt to describe the pathologic changes in the nervous system on an anatomical basis, but groups them under "cerebral manifestations" in cardiac diseases, vascular diseases, toxic diseases, blood dyscrasias, arterial hypertension, polyneuritis and neuritis, lung and liver diseases. In his effort to correlate and close the gap between clinical symptoms and pathologic findings, he has produced many excellent chapters of clear and concise analysis of the many problems involved.

His explanation of the reversible (functional) vascular disturbances (vasoparalysis or angiospasm, vasoparalysis, and vasothrombosis) will undoubtedly clarify your ideas and give you a different conception of their relationship to clinical symptoms. His personal observations of cerebral hemorrhages in hypertension as being due to prolonged stasis and congestion of the veins (resulting in degeneration and necrosis of the walls of the veins) and not due to rupture of the arteries, well

supported by pathologic findings in his so-called little or "ball" hemorrhages, give you an entirely different picture of the mechanism of cerebral hemorrhage.

On the whole, the material of his book is well chosen and presented, also easily understandable, and brings you the latest views on neurological problems.

MON-FAH CHUNG, M.D.

### Scientific Principles in Nursing

By M. Esther McClain, R.N., B.S., M.S., 410 pp. Price \$3.00. C. V. Mosby Company, St. Louis, Missouri, 1950.

It would certainly be a great convenience to nursing instructors if they could find one text to cover all scientific principles underlying nursing. But of course so much material could not be pressed between two book covers. This author has attempted to cover too broad a field for a modern text.

Yet several chapters are excellent. The one on "Care of the Dying" is thoroughly descriptive. That on "Diagnostic Tests" includes a concise outline of common tests done in medical laboratories, while the one on "Observation" is outlined clearly in sufficient detail. The chapters covering nursing the patient are followed by check lists of nursing performance which most clinical instructors will find helpful.

Though the author does not delve deeply enough into any science for this book to be depended upon as a text for nursing arts in a professional nursing school, it might make a good supplement for practical nurse students.

B. SCHIFFMAN, R.N.

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 308th regular meeting of the Hawaii County Medical Society was called to order by the President, Dr. T. David Woo, at 7:00 p.m., May 12, 1951, at The Lanai. **Drs. Samuel D. Allison, Nicholas Steuermann, Edmond H. Harrison, G. N. Stemmermann and Herbert F. Traut** were present as guests.

A motion to adopt the proposed amendment (that Chapter II, Section 2 of the Constitution and By-Laws be amended to read "Quorum: Ten members shall constitute a quorum.") was carried unanimously.

Since **Dr. Ernest B. Cunningham** was leaving for the mainland to practice, his application for certificate under interstate reciprocity agreement was brought up for discussion. Action of the society in recommending Dr. Ernest B. Cunningham as being worthy of recognition and of the privileges of reciprocity in any other state was necessary to complete his application. It was moved and seconded that he be recommended provided his dues for 1951 are paid. Motion was carried unanimously.

A letter by J. F. Ramsay, Manager of Hawaiian Agricultural Co. of Pahala, Kau, Hawaii requesting a letter of recommendation from the Hawaii County Medical Society to Dr. Tilden, in granting a waiver of residential requirements to **Dr. Robert J. Kaufmann** of Berwyn, Illinois, who has intention of working at Pahala, was read. After a short discussion it was moved that Dr. Robert J. Kaufmann be recommended for such a waiver of residential requirement, provided he agrees to sign a contract to remain at Pahala for at least a period of one year. Motion passed by unanimous vote.

There being no further business, the meeting ended at 7:20 p.m. The remainder of the evening was spent in hearing talks on Functional Uterine Bleeding, Endometrial Hyperplasia, Pre-eclampsia, and Eclampsia. This was followed by a general discussion on these subjects.

FRANCIS F. C. WONG, M.D.  
*Secretary*

## HONOLULU COUNTY MEDICAL SOCIETY

The June meeting of the Society was held on June 1, 1951, at 7:30 P.M., in Mabel Smyth Auditorium with **Dr. John William Devereux** presiding and approximately 55 members and guests present. The scientific program was as follows:

"Pheochromocytomas"—**Dr. Robert J. Kositchek**

"Duplication of the Upper and Mid-Urinary Tract, Associated with Utricular Cyst"—**Major Dougald McClain**

"Study of Renal Lymphatics as Correlated with the Study of Chyluria"—**Dr. Shoyei Yamauchi**

The appointment of **Mrs. Jeanne Deter** as executive secretary to the Society was announced.

**Dr. Lyle Phillips**, President of the Hawaii Residents' Association, explained the purposes of IMUA and requested the Society to endorse the proposals as outlined in the letter from that organization.

Although there was considerable pro and con discussion, no definite action was taken. The Board of Governors made the following recommendation at their meeting of May 22, 1951.

"That the members of the Board of Governors, as individuals, are in full accord and are sympathetic with the aims and objectives of IMUA, but feel that the Medical Society, as an organization, should not endorse the proposal as presented and requested in the letter from IMUA."

Meeting adjourned at 9:45 P.M. to refreshments on the lanai.

WILLIAM S. ITO, M.D.  
*Secretary.*

## KAUAI COUNTY MEDICAL SOCIETY

The regular meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital at 7:30 p.m. on Wednesday, April 11, 1951, with President, **Dr. K. Fujii** presiding. **Dr. William H. Bernhoff** of Buffalo, New York was guest speaker.

**Dr. M. A. Brennecke** was chosen to succeed **Dr. Sam Wallis** on the Board of Directors of the H.M.S.A. for the ensuing 2 years.

**Dr. Clyde H. Ishii** was elected Secretary-Treasurer by a secret ballot to replace **Dr. Steuermann**, who has taken a position at Olaa Plantation in Hawaii.

**Drs. Wallis, Kuhns and Wade** were appointed by the president to the Medical Services Committee of the Kauai Chapter, Hawaii Cancer Society designating Dr. Kuhns as chairman.

Dr. Bernhoff spoke on "Proctology" with special emphasis on anorectal tumors. Interesting lantern slides were presented.

Meeting adjourned at 9:45 p.m.

The May meeting was held at the G. N. Wilcox Memorial Hospital library at 7:30 p.m. on Wednesday the second 1951, a week in advance in order to accommodate special guest speakers.

**Dr. Fujii**, president, introduced the speakers, **Drs. Nicholson Eastman**, Obstetrician and Gynecologist, John Hopkins Hospital, Baltimore, and **Herbert F. Traut**, Gynecologist in Chief, University of California.

The entire evening was devoted to a round table discussion covering several interesting subjects in gynecology and obstetrics.

Meeting adjourned at 10:45 p.m.

The regular meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital at 7:30 p.m. on Wednesday, June 13, 1951, with President **Dr. K. Fujii** presiding.

A letter from Mr. C. J. Fern, chairman of the Kauai Chapter National Foundation for Infantile Paralysis, to Dr. Wallis was read. It was voted that this Society be wholly in favor of the proposal of sending Dr. Lee of the Board of Health to the polio conference in Copenhagen.

The membership status of **Dr. Donald Chisholm** was



## 40 Years.....

ON August 11, 1951, Hawaii's oldest Insurance Company (i.e., an insurer which issues its own policies) will have served Island people for 40 years.

IT IS interesting to note that our combined home office and general agency organization has increased during these years from three people to more than 150—a substantial contribution to the credit side of our Island economy.

WE OF the "Home" are grateful to the hundreds of Professional men and women of the community who have contributed to our consistent growth.

**HOME**  **INSURANCE CO.**  
**OF HAWAII, LTD.**  
HOME INSURANCE BLDG. • 129 S. KING ST. • HONOLULU, HAWAII, U.S.A.

KING ST., BETWEEN FORT AND BISHOP

TELEPHONE 6-3521

*The Purpose of All Forms of  
Insurance is Security*

discussed. Since he has not been in active duty for sometime, it was voted that his membership status be changed from an active to an honorary one.

It was voted that in the event a physician join the Armed Services his membership status in the Society remain intact until his return and that his fees and dues be automatically cancelled during the time of absence.

The Society unanimously approved the resolution passed by the Association of State and Territorial Health Officers at the Forty-ninth annual conference of that association held in Washington, D. C. last October; that is, the fluoridation of water supplies in the urban areas of Kauai County.

**Dr. A. S. Hartwell's** letter concerning another Cardiac Clinic on Kauai sometime this summer was read. It was duly moved and seconded that the Society be in favor of another clinic; that preferably two specialists be secured and that the date of this meeting be at their discretion.

The Society went on record as wholly approving the Fee Schedule formulated by the Professional Advisory Committee of the Honolulu Chapter, National Foundation for Infantile Paralysis, in cooperation with the Honolulu County Medical Society.

A film was presented which showed surgical procedures in the treatment of the lower extremities following infantile paralysis.

CLYDE H. ISHII, M.D.  
*Secretary*

### MAUI COUNTY MEDICAL SOCIETY

Meeting of the Maui County Medical Society was held May 9, 1951 at Club El Amigo in Wailuku. Thirty doctors and their wives were present.

The special guests were **Dr. Nicholson Eastman**, Gynecologist and Obstetrician in Chief, John Hopkins Hospital, Baltimore, and Mrs. Eastman; **Dr. Edmond H. Harrison, Jr.**, obstetrician of Baltimore, and Mrs. Harrison.

Members of the Maui Woman's Auxiliary were present.

The first portion of the meeting was devoted to cocktails and dinner, after which the ladies went to the home of Dr. and Mrs. K. Izumi where a pleasant evening was spent.

A scientific meeting was conducted with **Dr. R. J. McArthur**, program chairman, introducing the guest speakers, Drs. Eastman and Harrison.

Dr. Eastman presented the subjects of Treatment of Eclampsia, and Treatment of Threatened Abortion. Dr. E. Harrison spoke on Analgesia and Anesthesia in obstetrics.

EDWARD S. KUSHI, M.D.  
*Secretary*

Clinic Business Administrator, experienced medium sized clinic. Age 32, married, college graduate, seeking better opportunity. Please write details.

ROBERT SPOHN  
9223 MANZANAR  
DOWNEY, CALIFORNIA

## NOTES AND NEWS

**Mrs. Edith C. Bennett**, our efficient Managing Editor and Executive Secretary of the Hawaii Territorial Medical Association, has recently left by United Air Lines on an extended trip to the mainland and Europe. She accompanied her husband, **J. Gardner Bennett**, Professor of Civil Engineering at the University of Hawaii, who is on sabbatical leave from his post until the spring semester. They will visit in San Francisco, Denver, Cedar Rapids, Boston, and the states of Wyoming and New Jersey.

They plan to leave early in August for England; then they will go to Denmark, Norway, and Sweden, returning to Scotland and Ireland for a visit before turning south to France and Portugal. They will return to the East coast in time to spend Christmas with their relatives and drive to San Francisco via the southern route and expect to be back in Honolulu the end of January.

**Dr. A. S. Hartwell**, Hawaii Territorial Medical Association delegate to the AMA convention, left for Atlantic City on June 9 and **Dr. Homer Izumi**, alternate delegate, left on June 10; they represented the medical society at the AMA meeting at Atlantic City.

**Dr. C. C. McCorriston**, of Honolulu, will return from a three months' trip to the mainland in the latter part of August. He attended the AMA meeting in Atlantic City.

**Dr. Robert B. Faus**, of Honolulu, has returned from Washington, D. C., where he attended a Board of Health hearing before the subcommittee, Department of Interior and Insular Affairs, for federal assistance to the Territory of Hawaii for the treatment of leprosy.

**Dr. Clarence W. Trexler**, of Honolulu, has recently attended the annual meeting of the Pacific Coast Ophthalmological Society held in Victoria, B. C., at which he was elected Vice-president of the society for the coming year. The Hawaii Eye, Ear, Nose, and Throat Society has invited the group of 600 to 700 members at the Victoria meeting to meet in Honolulu at some future date.

**Dr. William J. Holmes**, of Honolulu, has been elected to membership in the *Société Française d'Ophthalmologie*. He also attended the AMA meeting in Atlantic City.

**Dr. Morton E. Berk**, of Honolulu, has returned from a meeting of the American College of Physicians in St. Louis from April 9 to 13. Dr. Berk was certified by the American Board of Internal Medicine in the subspecialty of cardiovascular disease.

**Dr. Charlotte Florine**, of Honolulu, has returned from an extended visit to the mainland. She attended the American Academy of General Practitioners meeting in San Francisco, before taking a trip through Central America. She went to St. Louis, where she was a guest at the American College of Physicians meeting. She also visited her home town, Cherokee, Iowa.

**Dr. and Mrs. John Frazer**, of Honolulu, have recently returned from a trip to the mainland. Dr. Frazer was present at the American College of Surgeons meeting in Atlantic City. Following this he did some special graduate work in plastic surgery.

**Dr. Fred Giles**, of Honolulu, has left for the mainland, where he will attend the American Medical Association meeting and then take some graduate courses in Boston. Following his studies the Giles family will go westward for a vacation.

**Dr. and Mrs. Steele Stewart**, of Honolulu, have recently returned from an European tour. Dr. Stewart presented a paper at the International Society of Orthopedic and Traumatological Society in Stockholm, Sweden.

The St. Francis Hospital, of Honolulu, has added two new surgical residents to the house staff. **Dr. Thomas T. Harada**, a native of Kau, Hawaii, is a graduate of the University of Hawaii in 1940 and the Temple University Medical School in Philadelphia in 1943. He served his internship at the St. Joseph's Hospital, St. Paul, Minnesota. Following this he spent three and a half years in the United States Army Medical Corps and upon discharge received his surgical training at the Veterans' Hospital in Minneapolis and at the University of Minnesota Graduate School, University Hospital, Minneapolis. **Dr. Francis Au**, a native of Honolulu, Hawaii, a graduate of Jefferson Medical College in 1949, has completed two years of surgical residency at The Queen's Hospital and will serve a further surgical residency at St. Francis Hospital.

The Kapiolani Maternity & Gynecological Hospital, of Honolulu, has three new residents since July 1951. They are: **Dr. Kenneth Cantwell**, a native of Yakima, Washington, who was graduated from the College of Medical Evangelists in Los Angeles. He served his residency at the St. Luke's Hospital, of Spokane, Washington, and served two years in the United States Army. **Dr. James Edward Mitchell**, a Queen's Hospital interne in 1949 to 1950, will begin his residency. He is a native of London, England, and is a graduate of Cork University, Ireland. He has recently served his residency in obstetrics and gynecology at the Johns Hopkins University Hospital for a year. **Dr. Gordon Alfred Newell**, a native of Stratford, Ontario, Canada, is a graduate of College of Medical Evangelists in Los Angeles and served his internship at the Hollywood Presbyterian Hospital in California before coming to Honolulu.

The Queen's Hospital, of Honolulu, announces the addition of seven Island residents to their interne staff as follows: **Dr. Gordon Chang**, of Honolulu, a graduate of Creighton University School of Medicine; **Dr. Elaine Chong**, of Honolulu, a graduate of Women's Medical College of Philadelphia; **Dr. Gilbert Ching**, of Kauai, a graduate of Boston Medical School; **Dr. Norman Chu**, of Honolulu, a graduate of New York Medical College, New York City; **Dr. Noboru Ogami**, of Honolulu, a graduate of Boston University Medical School; **Dr. John Sedgwick, Jr.** (the son of Mr. John Sedgwick, Business Manager of the Medical Group, Honolulu), a graduate of University of Pennsylvania School of Medicine; and **Dr. Richard Yamauchi**, of Honolulu, graduate of Hahnemann Medical College in Philadelphia. The other six internes are from various states, Canada, and Scotland and are as follows: **Dr. Robert Dimler**, of Milwaukee, a



graduate of Marquette University School of Medicine; **Dr. Helen Klevickis**, of Kenosha, Wisconsin, and **Dr. William Nilssen**, of Emerald, Wisconsin, are graduates of University of Wisconsin Medical School; **Dr. Cecil Saunders**, of Los Angeles, California, a graduate of University of Southern California Medical School; **Dr. Eugene Swanzey**, of Lewiston, Montana, and **Dr. Alexander Thomson**, of Glasgow, Scotland, are graduates of McGill University, of Montreal, Canada.

Children's Hospital, of Honolulu, announces three new staff members: **Dr. George T. Critz**, chief resident, a native of Cincinnati, Ohio, is a graduate of Western Reserve School of Medicine. He served his internship at Christ Hospital, Cincinnati, and U. S. Naval Hospital in Chelsea, Massachusetts. **Dr. Joseph H. Pritchett, Jr.**, assistant resident, a native of Decatur, Georgia, is a graduate of the University of Georgia School of Medicine and served his internship at Aiken Co. Hospital, Aiken, South Carolina, and also served at the U. S. Naval Hospital, in Jacksonville, Florida. **Dr. Francis L. deMarneffe**, assistant resident, a native of Banbury, England, is a graduate of King's College and Westminster Hospital Medical School of the University of London. He served his internship at Muhlenberg Hospital, in Plainfield, New Jersey. Mr. Robert Kim, a pre-medical student, a native of Wahiawa, Oahu, a graduate of University of Oregon, in Eugene, Oregon, will spend the summer months at Children's Hospital.

**Dr. Casimir Domzalski**, of The Clinic, Honolulu, has gone to the Mayo Clinic, Rochester, Minnesota, for a two-year fellowship in internal medicine.

**Dr. and Mrs. Maurice Gordon** have returned from the mainland where they attended the wedding of their son Lawrence, who was married to Miss Betty Colkett, daughter of Mr. and Mrs. Burton Colkett, of San Francisco, at the Grace Cathedral in San Francisco on June 30. The Gordons previously went to Victoria, B. C., to the Pacific Coast Ophthalmological Society meeting, following which they journeyed to Alaska.

**Dr. Donald T. Nakashima**, a native of Honolulu, has commenced his internship at the Tripler Army Hospital, of Honolulu, following his graduation from the University of Nebraska College of Medicine in June.

**Dr. Gail Li**, the son of **Dr. and Mrs. Min Hin Li**, of Honolulu, was married in Detroit to Miss Nani Choy Sing Au Hoy, of Honolulu. The bride is a graduate of Hawaiian Mission Academy, La Sierra College and Glendale Hospital School of Nursing. She is now with the Grace Hospital in Detroit. Dr. Li is specializing in obstetrics and gynecology at the Wayne University College of Medicine and has received the National Cancer Institute Fellowship for special training in gynecological cancer.

**Dr. and Mrs. J. Warren White** have attended the American Medical Association meeting in Atlantic City and the American Orthopedic Society convention in Sulphur Springs, West Virginia.

The following two Honolulu physicians are the latest to serve their country in the armed forces and have reported for active duty—**Dr. Yasuyuki Fukushima** and **Dr. K. S. Chang**. They have been commissioned 1st Lt. in the United States Army Medical Corps.

**Dr. Nils P. Larsen**, of Honolulu, has recently returned from a five week tour on the mainland, during which time he attended the American College of Physicians meeting in St. Louis. Dr. Larsen is governor of the Hawaii chapter of the College. From there he went to

## IGA MORI, M.D. 1864 - 1951

Dr. Iga Mori, 87, kamaaina Honolulu retired physician and surgeon, died at the Kuakini hospital on May 12 at 3:30 a.m. after having been in failing health for the past several years.

One of the oldest surviving members of the Hawaiian Medical Society, now known as the Hawaii Territorial Medical Association, Dr. Mori was elected an honorary member of the Honolulu County Medical Society on April 26, 1949.

Born in Ishikawa prefecture, Japan, on February 11, 1864, Dr. Mori first came to Hawaii in August, 1890, as physician for the Bureau of Immigration of the Kingdom of Hawaii. Four years later he returned to Japan to become chief surgeon of the First Corps of the Japan Red Cross in the Sino-Japanese War, 1894-95. Since 1904, he had been a permanent resident of Honolulu, dean of the medical profession and active worker in civic affairs.

Dr. Mori was educated at the Naval Medical College of Tokyo, Japan (1888), Cooper Medical College of Stanford University (1891), University Hospital, London (postgraduate course 1898), and Post Graduate Medical School, New York (1904).

He was one of the founders and past president of the Japanese Benevolent Society of Hawaii, and former superintendent of the Japanese Charity Hospital of Honolulu, now the Kuakini Hospital.

He was also a member of the Hawaii Group of the Institute of Pacific Relations, Pan-Pacific Union, Prince Fushimi Memorial Scholarship Society, the Honolulu YMCA, American Red Cross, Board of Hawaiian Evangelical Association, Hawaii Historical Society, and the Honolulu Art Society.

Surviving Dr. Mori are his son, Dr. Motokazu Mori, himself a veteran local physician and surgeon, nine grandchildren, and four great-grandchildren.

He and Mrs. Mori, who died in Honolulu on September 13, 1946, celebrated their golden wedding anniversary in 1940.

SHIGEO SOGA

his alma mater, Cornell. Following this he attended the ACP course at the University of Pittsburgh. Leaving Pittsburgh, Dr. Larsen flew to Mexico and Yucatan, where he spent a week taking photographs of pre-Hispanic ruins.

**Dr. Charles L. Wilbar, Jr.**, president, Board of Health, and **Dr. Robert B. Faus**, Board member, appeared before Congress in April to ask for Federal aid for the Hansen's disease program in Hawaii. The more than a million dollars appropriation has now passed the House, and is before the Senate.

**Dr. Yan Tim Wong**, psychiatrist, bureau of mental hygiene, has been appointed acting chief of the bureau, replacing **Dr. John G. Lynn IV**, who resigned to enter private practice.

**Dr. Max Levine**, chief of the bureau of laboratories, Department of Health, presented a paper on hemagglutination of tuberculin sensitized sheep cells in Hansen's disease at a conference of the Society of American Bacteriologists held in Chicago, May 27-31. He also participated in a symposium on spores, where he discussed disinfection of spore forming resistant bacteria. He led a discussion on the classification of the intestinal group of bacteria.

At least 14 Hawaii physicians, many of them with their wives, were present at the recent Atlantic City session of the A.M.A. Noticed were: **Dr. and Mrs. Louis A. R. Gaspar**, **Dr. and Mrs. J. Warren White**, **Dr. and Mrs. F. L. Giles**, **Dr. and Mrs. Patrick Cockett**, **Dr. and Mrs. R. B. Cloward**, **Dr. and Mrs. C. M. Burgess**, **Dr. and Mrs. P. J. Washko**, **Dr. and Mrs. C. C. McCorriston**, **Drs. G. M. Batten**, **A. V. Molyneux**, **F. J. Halford**, **Leabert Fernandez**, and last but perhaps most, our Alternate Delegate and Delegate, **Drs. Homer Izumi** and **A. S. (Bill) Hartwell**.

**Dr. R. B. Cloward** was awarded an Honorable Mention for his exhibit on a new technic of spinal fusion at the A.M.A.

**Dr. L. Clagett Beck** read a paper on Duodenal Ulcer in Hawaii before the American Therapeutic Society at their meeting early in June.

**Dr. Fred I. Gilbert, Jr.**, has returned to Honolulu and joined the Department of Internal Medicine of The Clinic. Dr. Gilbert attended Punahou and the University of Hawaii and the University of California as an undergraduate, and was graduated from Stanford University School of Medicine in 1945. He interned there in surgery, following which he served two years in the U.S. Army as a psychiatric officer. After discharge from the service in 1948 he completed a two-year residency in medicine at Fort Miley, in San Francisco. In 1947 he was appointed a Special Worker in Medicine at Stanford; in 1949 he became a teaching assistant, and in 1950 Clinical Instructor of Medicine. From July 1950 to January 1951, he served as locum tenens for **Dr. Sam R. Brown** in Hilo, where he became a member of the Hawaii County Medical Society. Dr. Gilbert is married to the former Helen Odell (Punahou '39) and has three children as we go to press.

On July 1, 1951, **Dr. David K. Geddes** joined the psychiatric staff of **Dr. Richard D. Kepner**. He will limit his practice to psychiatry and psychoanalytic therapy. Dr. Geddes received his medical degree from the University of Maryland, Baltimore. Following his internship at The Queen's Hospital, Honolulu, he was a resident in psychiatry for one year in the Department of Psychiatry at Yale University, and for two years at St. Elizabeths Hospital, Washington, D.C. He also spent two years at the Washington School of Psychiatry, specializing in psychoanalytic therapy. He has undergone individual psychoanalysis. Dr. Geddes is a member of the Washington Psychiatric Society, the Medical Society of St. Elizabeths Hospital, and an associate member of the American Psychiatric Association.

## Hawaii

**Dr. H. P. Allison**, formerly of Tacoma, Wash., is now practising in Hilo under the sponsorship of Dr. Samuel R. Brown. Dr. Allison is an orthopedic surgeon.

**Dr. and Mrs. Grant N. Stemmermann** traveled all the way from Hendersonville, N. C., to make their home in Hilo. Dr. Stemmermann is now the pathologist for the

Hilo Memorial Hospital. He is certified in anatomic pathology by the American Board of Pathology. He is a graduate of McGill University and interned at Montreal General Hospital, Montreal, Canada. He had post-graduate training at Sea View Hospital, Staten Island, N. Y., and at Halloran V. A. Hospital, Staten Island, N. Y.

**Dr. and Mrs. Nicholas Steuermann** changed their residency from Kauai to Hawaii recently. Dr. Steuermann is the new plantation physician for Olaa Sugar Co. He was formerly the plantation physician for McBryde Sugar Co. on Kauai, and a member of the Kauai County Medical Society.

**Dr. Fred Irwin** is now practicing in Naalehu. Dr. Irwin was formerly the medical director of the HMSA.

**Dr. Richard Neil**, plantation physician for Olaa Sugar Co., and **Dr. Marion L. Hanlon** of Kohala will be called into active duty by the Medical Corps of the U. S. Army in the immediate future. Our very best wishes are with them.

**Dr. and Mrs. Cunningham** of Pahala left Hawaii to practice medicine in Tennessee.

**Dr. and Mrs. Gaenge** of Pepeekeo, Hawaii, will leave in June for a residency in Psychiatry at Kaneohe Hospital, Kaneohe, Oahu. Dr. Gaenge has been a plantation physician for the Pepeekeo Sugar Company for about two years.

**Dr. Leo Bernstein**, County Health Officer for the Big Island, has been appointed and approved as Administrator of the new Division of Hospitals and Medical Care of the Board of Health. Dr. Bernstein was the immediate past president of the Hawaii County Medical Society. He has been very active with civic affairs in Hilo. **Mrs. Bernstein** is the present president of the Auxiliary to the Hawaii County Medical Society.

**Dr. Herbert F. Traut** of University of California Medical School and **Dr. Edmund P. H. Harrison, Jr.**, of Baltimore, Md., were the guests speakers at our medical society meeting held on May 12, 1951.

## Kauai

**Dr. Nicholas Steuermann** has recently left to accept a position as Plantation Physician at Olaa, Hawaii.

**Dr. Gus Bieber** has left for the mainland where he has obtained a hospital residency.

**Dr. D. R. Chisholm**, formerly Medical Director of Mahelona Hospital, has been voted an honorary membership in our Society.

## Maui

Maui County Medical Society together with the Woman's Auxiliary enjoyed a dinner and scientific meeting with **Dr. and Mrs. N. Eastman** and **Dr. and Mrs. E. Harrison**, of Johns Hopkins University, who visited Maui in May. The visitors were the guests of **Dr. and Mrs. William D. Patterson**, of Puunene, Maui, who showed them real Maui hospitality including a trip to Haleakala and other sightseeing trips.

**Back home from the Hawaii Territorial Medical Association.** All tired, but willing, the following are back at work after having a wonderful time in Honolulu: **Dr. and Mrs. Al Burden**, of Halimaile; **Dr. Edward Shimokawa**, of Lahaina; **Dr. and Mrs. William Wilkinson**, of Lanai; **Dr. and Mrs. Harold Kushi**, of Kahului; **Dr. and Mrs. John I. Reppun**, of Molokai; **Dr. and Mrs. John Sanders**, of Paia; **Dr. T. W. Kanda**, of Wailuku; **Dr. and Mrs. Ed. Tompkins**, of Kula; **Dr. and Mrs. William Patterson**, of Puunene; **Dr. and Mrs. Edward B. Underwood**,



## Head Pain as a Diagnostic Lead

Frequently the presence of head pain is overlooked. The physician learns of it only if he has made an effort to elicit the information. Since the etiology of the pain is the basis of rational management, the patient should be warned against taking medication before diagnosis is made.

Friedman<sup>1</sup> deplores the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache — its character, laterality, frequency and intensity.<sup>2</sup>

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic, analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain not related to b.p. level; Dihydroergotamine relieves pain.	General hypertension therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g-i. upset during headache.	To abort attack: oral ergotamine plus caffeine.  General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,<sup>3</sup> and Friedman, A. P.<sup>4</sup>

Cecil<sup>5</sup> ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

1) *Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.*

2) *Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.<sup>1,6</sup> The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.*

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 54:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563; Saunders Co., Phila. 5. Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

## Sandoz Pharmaceuticals

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, NEW YORK

of Puunene; **Dr. Jesse I. Knox**, of Molokai; and **Dr. and Mrs. Edward Kushi**, of Wailuku. Maui can be proud that we always try to attend the annual convention no matter where it is held.

**Dr. Edward Kushi**, our local editor on Maui, who is chairman of the Maui Hospital Managing Committee in addition to his active general practice, has been appointed by the Governor as one of Maui County Police Commissioners.

**Dr. and Mrs. Louis Rockett**, of Wailuku Sugar Plantation, are building a new home in the Puuoni tract, and will move in soon.

The stork will soon be making deliveries to these lucky people: **Dr. and Mrs. Lester Kashiwa**, of Wailuku; and **Dr. and Mrs. Guy S. Haywood**, of Puunene.

## Woman's Auxiliary

The Woman's Auxiliary to the Hawaii Territorial Medical Association held its annual meeting May 4, 1951, at the time of the annual meeting of the Medical Association. The new officers of the Territorial Auxiliary are:

President.....	<b>Mrs. R. G. Johnston</b>
President-Elect.....	<b>Mrs. Garton Wall</b>
First Vice President.....	<b>Mrs. J. Warren White</b>
Second Vice President.....	<b>Mrs. H. B. Yuen</b>
Recording Secretary.....	<b>Mrs. Teruo Yoshina</b>
Corresponding Secretary.....	<b>Mrs. K. S. Tom</b>
Treasurer.....	<b>Mrs. R. D. Kepner</b>
Executive Board Members.....	<b>Mrs. Lyle Phillips</b> <b>Mrs. J. W. Cooper</b>

## International College of Surgeons

The Sixteenth Annual Assembly of the United States Chapter of the International College of Surgeons will be held in Chicago on September 10 through 13, 1951, with headquarters at the Palmer House.

An excellent program has been arranged. Prominent surgeons from the United States and other countries will participate. Scientific sessions will be held by all specialty sections of the United States chapter.

Hotel reservations may be arranged by writing to the Housing Division, Chicago Convention Bureau, 33 North LaSalle Street, Chicago 2, Illinois.

## Honolulu Surgical Society

This society held a meeting in the Mabel Smyth Lounge in May where the speakers were **Comdr. William H. Gullledge**, resident in orthopedics at the Shriners' Hospital, Honolulu, who reported on his experiences in the Korean campaign earlier this year. **Dr. J. E. Strode**, of Honolulu, gave a very illuminating discussion on surgical papers which he heard at recent meetings of the American Surgical Association in Washington, D. C., and of the American Association of Thoracic Surgery in Atlantic City.

## Arthritis Research Fellowships

The Arthritis and Rheumatism Foundation is offering research fellowships in the basic sciences related to arthritis. Fellowships will be granted at both the predoctoral and postdoctoral levels. The predoctoral fellowships will range between \$1,500 and \$3,000 per annum, and the postdoctoral from \$3,000 to \$6,000. The deadline for these applications is November 15, 1951. Application forms may be obtained by writing the Medical Director, Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, N. Y.

*Come***STRIKES****H - - -****OR****HIGH WATER**

IT IS A MATTER OF RECORD THAT NONE  
OF OUR CUSTOMERS HAVE SUFFERED  
FOR LACK OF PROPER MEDICATION.

THIS PHARMACY IS CON-  
STANTLY SEARCHING FOR  
IMPROVED METHODS AND  
PRODUCTS FOR LOCAL PRE-  
SCRIPTION COMPOUNDING  
AND YOUR PATIENTS' INDIVID-  
UAL NEEDS.

**McARTHUR & SUMMERS****PRESCRIPTION • PHARMACISTS**PHONES 6-6044  
6-8865THIRD FLOOR • YOUNG BUILDING  
HONOLULU, HAWAIIEMERGENCY PHONE  
7-8411



# Sixty-first Annual Meeting

## Hawaii Territorial Medical Association

**Honolulu, Hawaii**  
**May 3-6, 1951**

The sixty-first annual meeting of the Hawaii Territorial Medical Association was held in Honolulu, Hawaii, with scientific meetings and exhibits being held in the Mabel Smyth Memorial Building. The following program was presented:

### SCIENTIFIC PROGRAM

*Obstetrical Hemorrhage*, by Nicholson J. Eastman, M.D.  
(by special invitation)

*Symposium on ACTH and Cortisone:*

*Observations on the Effects of Cortisone and ACTH in Bronchial Asthma and Rheumatic State*, by Frederick L. Giles, M.D., and Doss O. Lynn, Lt. Col., USAMC.

*Cortisone and ACTH in the Treatment of Ocular Disease*, by W. John Holmes, M.D., and H. E. Crawford, M.D.

*ACTH and Cortisone in Dermatology*, by Harry L. Arnold, Jr., M.D., and Harold M. Johnson, M.D.

*Medicine Looks to the Future*, by Rogers Lee Hill, M.D.

*Bubonic Plague*, by Clarence L. Carter, M.D.

*Hypersplenism*, by Thomas Fujiwara, M.D., and Laurence M. Wiig, M.D.

*Some Common Arrhythmias and Their Treatment*, by F. Bernard Schultz, M.D.

*Cytological Diagnosis in Obstetrics and Gynecology*, by Herbert F. Traut, M.D. (by special invitation).

*Report of the Hawaii Cancer Society Cytology Laboratory*, by Frank C. Spencer, M.D.; I. L. Tilden, M.D., and Walter B. Quisenberry, M.D.

*Chemo-Surgery and Plastic Surgery in the Management of Facial Cancer*, by Wayne W. Wong, M.D.

### MEETINGS

*Advisory Committee to the Bureau of Crippled Children*, Thursday morning, Mabel Smyth Memorial Building.

*Advisory Committee to the Bureau of Maternal and Child Health*, Thursday afternoon, Mabel Smyth Memorial Building.

*Council*, Thursday evening dinner, The Pacific Club.

*Woman's Auxiliary—House of Delegates*, Friday morning, 11:00, Mabel Smyth Memorial Building.

*Buffet Luncheon*, 12:30 Friday, Pacific Club, followed by *Annual Meeting*.

*House of Delegates*, Friday afternoon, 1:30, Mabel Smyth Memorial Building.

*House of Delegates*, Saturday morning, 9:00, Mabel Smyth Memorial Building.

### SOCIAL PROGRAM

*Cocktail Dinner Dance*, Saturday evening, Oahu Country Club.

*Golf Tournament*, Sunday morning, Waialae Golf Club; Frank C. Spencer, M.D., in charge.

*Picnic*, Sunday afternoon, 8:00, The Palms, 431 Nahua Place.

### NOTES

Scientific papers presented have been submitted for publication in the HAWAII MEDICAL JOURNAL.

There were scientific exhibits on the following subjects:

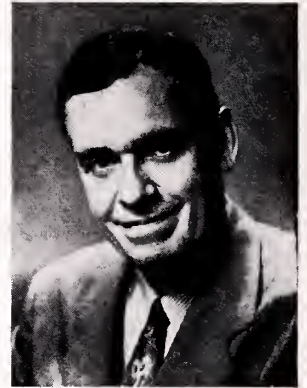
Cancer Cytology Laboratory  
Hawaii Chapter of the American Physical Therapy Association  
Honolulu Pediatrics Society  
Nutrition for the Pregnant Mother—Board of Health  
Tennis Elbow Lesions—Dr. Cooper

The address of the President, minutes of meetings and reports follow:

### ADDRESS OF THE PRESIDENT Medicine Looks to the Future

Rogers Lee Hill, M.D.

With the completion of the first half of the twentieth century, it is appropriate that the members of the medical profession of Hawaii reflect upon the progress of medicine in the past in order to prepare for the future. It would not be possible in a brief time, nor would it be necessary, to review or even enumerate all of the outstanding achievements of the past that have elevated medicine in this country to an unequaled position in the world today.



DR. HILL

Medicine does not belong to a single country. It is international in scope and the important contributions have come from many different sections of the world. It is significant, however, that certain countries have predominated in medical progress over a certain period of time. Undoubtedly this supremacy has been influenced by political, social and economical developments. The validity of this assertion can be easily established by a glance at the pages of medical history. A roughly accurate order of period supremacy by countries would be: Greece, France, England, Germany and America.

It is amazing that America has attained medical superiority in such a brief period, as the first medical school was founded in 1765 at Philadelphia, Pennsylvania, less than 200 years ago. In 1776, there were some 3,500 practitioners of medicine in this country but only 400 had received medical degrees. Today there are 202,683 physicians and the diploma mill has ceased to exist. Approximately 75% of these physicians are engaged in a private practice and 25% are serving in some administrative capacity.

American contribution to the field of medical progress in the past twenty-five years has been nothing short of phenomenal. This meteoric ascendancy may be attributed to three basic etiologic factors: the type of individual who came to the North American continent to live, the type of government he established, and the tre-

mendous natural resources he found at his disposal. A single one of these factors was enough to ignite the flames of progress, and all three combined created an irresistible force.

If one attempts to enumerate all of the causes of medical progress, serious difficulty is encountered because of the magnitude of the task. If one, however, explores this subject by examining some of the trends of the past, a direct application to future planning may be developed.

If I had to select a single causative agent that had contributed the most to medical progress in this country in the past 100 years, I believe I would list the American Medical Association first. The excellent job it has done in improving medical education is only one of many examples that could be cited. If the American Medical Association remains a strong and unified organization, as it undoubtedly will, then it will continue as a determining influence on medical practice of the future. Very little imagination is required to see the gradual deterioration of medicine with banishment of this strong organization.

No phase of human activity is static and medicine is certainly no exception. The changing trends of medical practice reveal how vastly different the practice of medicine is today than it was when our forefathers lived. Specialization, increased hospitalization, voluntary health insurance plans, increased span of life, nuclear fission, increased incidence of degenerative diseases and cancer, control of infections, reduction in infant and maternal mortality, elimination of many contagious diseases, endocrinologic advances, urbanization of population, blood transfusions, industrial expansion, wars, depressions, faster modes of travel, etc., have all wrought great changes in medical practice. Some of the changing trends have been brought about by our own activity but the majority are products of evolutionary social progress.

In retrospect I believe that we in the medical profession have been too slow to recognize and accept some of the changes in the past. Organized medicine's reticence in accepting voluntary health insurance plans is a good example of this neglect. Had we been more farsighted in recognizing this important social change some of our problems today might be less serious.

Considerable confusion exists today as regards the definition of the term socialized medicine. Certainly the concept today of this much debated question is dissimilar to that of twenty-five years ago. At that time it was so inclusive as to embrace almost any form of prepayment insurance plan and any salaried physician, government or otherwise. Some unjust criticism and abuse have been heaped upon our institutional physicians by including them in this category. If one placed the Board of Health physicians, or the Tuberculosis Hospital physicians, in this category one might also be so bold as to include plantation physicians, or even salaried members of a clinic. An indictment against consultants to Veterans' Hospitals or Army Hospitals might also be in order. My interpretation of the danger of so-called socialized medicine is the compulsory Federal Government Health Insurance, the evils of which are so apparent.

It is necessary, for the purpose of clarification, to differentiate between desirable and undesirable government participation in medical practice. Organized medicine should indicate precisely in what categories government participation is necessary and approved. As soon as we face the problem realistically, and admit that in certain chronic diseases like tuberculosis, government participa-

tion is necessary, then we will eliminate inconsistent thinking and ambiguous expressions and concentrate on the fundamental issues involved. The State and County Medical Societies have a wonderful opportunity to advance, and participate in constructive programs that will prevent *undesirable national and local political control* in this category of diseases. The recent formation of a legislative Medical Advisory Committee by the Holdover Committee of our legislature is an excellent example of such a progressive and forward movement, and its future continuation should be wholeheartedly supported.

Whether we realize it or not we have undergone a great industrial revolution in the past thirty-eight years, and never again will there be a return to what we hopefully term normalcy. The best we can hope for is an elimination of communism and a stopping of the present trend toward socialism. Many of the reforms that have swept over this nation were inevitable, but typically American, many have become too violent. There is indisputable evidence that a certain amount of moral decadence has developed in this country which will require a substantial adjustment if we are to avoid national deterioration. Our young generations must be taught thrift, honesty and community responsibility. As the young people think and go, so goes medicine of the future.

I urge that everyone of you support your County, State and National medical organizations. In the complex social order of today and tomorrow, with everything organized so thoroughly, control of medicine would eventually pass into lay hands without an efficient organization to combat it. This does not mean passive support. It means personal and individual participation. If you are not in accord with policies and plans of your Society, it is your duty to remain an active member and attempt to institute change and reform. There has been much criticism of the American Medical Association in the past and undoubtedly some of it has been justified; however, it remains your sole hope in the medical world of tomorrow. It is apparent that the parent organization has recently been infused with more youthful concept, enthusiasm and a determination to meet the problems of today with a positive and realistic attitude. No longer is there indecision and a negative program with its resulting defensive attitude, so vulnerable to attack.

It has become increasingly apparent to State and County Medical Societies that their officers should not be selected solely on the basis of annual awards to old and distinguished physicians for fine deeds and exemplary character. These officers should be men of vision, imagination, ability and the intense desire to serve faithfully the electorate. It is to be hoped that these and other progressive changes will permeate the entire medical structure, gradually exterminating old political alliances and selfish interests. A somewhat parallel situation exists in our own medical society in the traditional method of geographical selection, of our president by periodic rotation. I believe this to be a restrictive and antiquated custom and urge its early discontinuance in the best interest of the society. The structural organization of our own medical society reveals a glaring weakness too in the broad powers delegated to the Council. This should be eliminated in the near future, as it is neither desirable nor democratic.

The action of the Board of Trustees of the American Medical Association at the Cleveland meeting, in appropriating one-half million dollars as an initial contribution to an annual fund to be raised by the medical pro-



fession to assist medical schools in financial distress, is one of the most constructive programs ever advanced by organized medicine. The formation of the American Medical Education Foundation is to foster the preservation of academic freedom in our medical schools. You are aware of the fact that, with the loss of the once plentiful private endowment and the general reduction in income from investments, many medical schools are staggering under a growing financial burden that is bringing them precariously close to insolvency. The American Medical Association is actively engaged in an attempt to prevent federal subsidization of medical schools. I need not point out to you the danger of such subsidization. The Supreme Court of the United States has ruled that what the Federal Government subsidizes it may control. An appreciation of the fundamental significance of the principles involved in this controversy should emphasize to you the importance of an organized national medical society and your continuing membership and personal participation. Your desire for membership retention will be still further strengthened if you will recall the old truism, "In union there is strength."

I need not emphasize the continuation of your loyal and patriotic devotion to the all important preparation for civil defense. The enemy's realization that a strong civilian defense exists may be one of the important deterrents to an all out war that would reduce medicine of the future to the impotence of the dark ages.

In erasing medical hazards in the past, new and baffling problems have been created. This may be compared to the part played by predatory animals in maintaining the balance of nature. We are already witnessing an increase in virus infections as the bacterial conquest becomes a reality. This is applicable to economic and social conditions as well as to the purely scientific. It was an inevitable fact that medical care would become more expensive with the tremendous increase in necessary laboratory and other diagnostic facilities. This high cost of medical care constitutes one of the most serious problems that we face today. As an antidote to this perplexing problem, voluntary health insurance plans have evolved. They are far from perfect but are demonstrating to the public that adequate medical care may be available in the future for a nominal fee, with free choice of physician and without undesirable federal dictation. Some unorthodox changes in the traditional methods of charges to patients may be inevitable, especially in the x-ray laboratory and other diagnostic fields. The voluntary insurance plans have the additional value of budgeting, which is an accepted economic custom in this country. In order for the various programs now in general use to remain solvent they must have the support of organized medicine and the public. By exercising the highest degree of honesty and cooperation you may greatly aid in expanding the plans into a more comprehensive coverage. There has developed a peculiar philosophy in this country that while it is wrong and dishonest to overcharge individuals, it is perfectly legitimate to exact all the traffic will bear from companies and other collective undertakings.

I see little necessity for a prophetic utterance about the future of the Specialist and the General Practitioner. Undoubtedly they are both here to stay, although their numerical dispositions may vary considerably in different localities. Trends influencing the number of specialists and the degree of specialism are as unpredictable as the sandy beaches of Hawaii, rising and falling with

the economic and other social conditions that prevail. It is to be deplored if professional animosities develop between these two groups that might interfere with good medical care. The American Specialty Boards were formed with the primary objective of certification. Unfortunately an undue amount of enthusiasm has swept the country and has resulted in an uneconomic trend that was not anticipated. It has also resulted in an undesired deterioration of the position and standing of the general practitioner. This frustrated and bewildered individual has at last realized the value of protective organization and cooperative endeavor. The American Academy of General Practice is a potentially powerful weapon and may enable the General Practitioner to regain his lost prestige. It is to be hoped that mutual understanding and cooperation between these groups will continue in order to reverse an uneconomic trend of medical practice that has developed in the past decade.

I think you will agree with me that a review of medical trends and progress over the past half century is enlightening. Many of the trends will undoubtedly continue in the future. I have read most of the papers that have dealt with future forecasts and have been sadly disappointed in their meaningless generalities and obvious attempts to reveal broad thinking and deep intellectual concepts. If one is honest and sincere as he gazes back at the past fifty years he is immediately impressed with the evolutionary changes that society is continually undergoing. These changes inevitably reflect themselves in the practice of medicine. We must be constantly aware of them and make necessary adjustments if we are to exist in the future as a free professional group.

It has been a privilege to have served as your President for the past year. It will always be a period upon which I will look back with a great deal of satisfaction. I appreciate the confidence you have placed in me by electing me to this exalted position. I apologize for my incapacities and incapacibilities. Whatever progress or accomplishment that has been made over the past year is due to the effort of many individuals. I am deeply grateful for the many contributions that have been made by participating members during the past year. It would be too time consuming to make personal acknowledgments and I only hope that you will extend the same fine cooperative spirit to my able successor.

It was felt that after completion of the last war, with its far flung and global encircling battlefields a period of peace and contentment could be expected for the species *Sapiens* of the genus *Homo*. This was not decreed however, and when Russia initiated war by proxy in Korea a pall of gloom and despair was cast over this nation and the entire world. This meant a complete abandonment of the hope for unarmed peace and resulted in a mad rush to fulfill the basic tenets of man's savage philosophy, "Kill or be killed." We should not feel so sad and pessimistic. This is not new experience for *Homo sapiens*. Down through the countless ages he has had plenty of trials, tribulations and adversity. I doubt seriously that he could live in peace and contentment. Certainly there would be no progress, for *Homo sapiens* will never remain stationary. There will be varied, complicated and difficult problems to face that will require courage, an infinite amount of patience, painstaking effort and an abiding faith in the future.

Remember Shakespeare once wisely said:

"Sweet are the uses of adversity,  
Which, like the toad, ugly and venomous,  
Wears yet a precious jewel in his head."

## MINUTES OF MEETING COUNCIL

Thursday, May 3, 1951 at 6:00 p.m.  
Pacific Club, Honolulu

*Present:* Dr. Rogers Lee Hill, presiding; Drs. I. L. Tilden, E. K. Chung-Hoon, B. O. Wade (Kauai), Herbert Rothwell, R. K. C. Lee, F. J. Pinkerton; also Drs. H. L. Arnold, Jr., A. S. Hartwell and Edward Kushi (Maui).

*Minutes:* The minutes of the December 15, 1950 meeting had been circulated. Since there were no corrections, the president stated the minutes were approved as circulated.

*Hawaii Medical Journal:* The Council considered the personnel of the Editorial Board for the coming year. It was decided to change Dr. Laurence Wiig's title from Assistant Editor to News Editor. Dr. H. H. Walker will remain in his present position. Dr. Homer Izumi will substitute for Dr. James R. Enright. Dr. Pete Okumoto will continue to serve as Associate Editor, Hawaii; Dr. Edward Kushi will be Associate Editor, Maui, and Dr. C. H. Ishii will be the Associate Editor, Kauai. The Editorial Board will then be made up as follows:

Harry L. Arnold, Jr., M.D.	.....Editor
Mrs. Edith C. Bennett	.....Managing Editor
Laurence M. Wiig, M.D.	.....News Editor
Homer Izumi, M.D.	.....Advisory Board
H. H. Walker, M.D.	.....Advisory Board
Pete Okumoto, M.D.	.....Associate Editor, Hawaii
Edward S. Kushi, M.D.	.....Associate Editor, Maui
C. H. Ishii, M.D.	.....Associate Editor, Kauai

**ACTION:** Dr. Wade moved that the Editorial Board be composed of the members set forth above; seconded by Dr. Chung-Hoon and unanimously passed.

Dr. Hill stated that the JOURNAL is one of our major assets, and we have done very little to show appreciation to Dr. Arnold as Editor. As a small token it was suggested that we pay Dr. Arnold's expenses at this annual meeting this year. It was also suggested that eventually we might be able to send Dr. Arnold to the AMA convention, but the budget could not be stretched to cover this at present.

**ACTION:** On motion of Dr. Lee, seconded by Dr. Tilden, the Council unanimously voted to pay the expenses incurred by Dr. Arnold to attend the 1951 annual meeting of this Association.

*Chronic Illness:* Mrs. Bennett read a letter Dr. Hill had received from Dr. Wilbar, asking the Territorial Medical Association to set up an advisory committee on chronic illness. Dr. Lee mentioned that the Advisory Committees on Crippled Children, Tuberculosis, and Maternal and Child Health, have been very helpful. Recently problems in connection with chronic illness have been coming to the fore, and there is a real need for an advisory committee from the medical profession. A suggestion was made that the president-elect appoint such a committee in conference with the President of the Board of Health.

**ACTION:** Dr. Tilden moved that the president be empowered to appoint an Advisory Committee on Chronic Illness.

*EMIC:* Dr. Hill announced that Dr. Nathan Sinai and Dr. Edwin F. Dailey will arrive in Honolulu tonight. We understand that they are being sent by the Children's Bureau of the Federal Security Agency and are making a tour through the country to explore the need for a program similar to the EMIC plan which

was in effect during the last war, and to inquire how the doctors would like to have such a plan set up. The meeting will be held tomorrow morning at 8 o'clock in the Mabel Smyth Auditorium. All interested physicians and hospital administrators will meet with these two men to discuss the various aspects of the proposed program. The Council members are urged to attend.

*Public Service Funds:* Ever since we have had a separate fund for Public Service, the only person authorized to sign checks has been Mrs. Bennett. Mrs. Bennett is expecting to be away for an extended leave of absence.

**ACTION:** On motion duly made and seconded, the Council unanimously voted that the Treasurer of the Hawaii Territorial Medical Association, or the Secretary in his absence, should be authorized to sign checks on the Public Service Committee funds on the approval of the Chairman of the Public Service Committee.

*Leave for Mrs. Bennett:* Mrs. Bennett informed the Council that her husband would have a sabbatical leave from the University of Hawaii for the fall semester of the year 1951-1952, and she plans to be away with her husband from June 1 to February 1, and would like to have a leave of absence from her position. The Council discussed a replacement for Mrs. Bennett during her absence.

**ACTION:** Dr. Pinkerton moved, seconded by Dr. Wade, that the officers of this Association be authorized to search the field and find someone to fill Mrs. Bennett's position during her absence, and pay what must be paid. Dr. Lee amended the motion to limit the officers to spend not more than would be paid in salary if Mrs. Bennett were here. The motion was unanimously passed as amended.

**ACTION:** Dr. Wade moved that Mrs. Bennett be given a month's vacation this year; seconded by Dr. Pinkerton and passed.

The matter of staff vacations was discussed. Dr. Pinkerton suggested we secure a copy of the policy regarding vacations and leaves from the Oahu Health Council; deviations may be made in the policy for a specific case. It was agreed that this would be done.

*Representation at AMA:* Dr. Hill reminded the Council that Dr. Hartwell's term as delegate expires December 31, 1951. Dr. Archie Orenstein's resignation has been accepted by the House of Delegates, and Dr. Homer Izumi was elected to fill the unexpired term to December 31, 1951. The Nominating Committee nominated Dr. Izumi as AMA delegate and Dr. Frank Spencer as alternate. The Honolulu County Board of Governors recommend that the Honolulu delegate support the return of Dr. Hartwell as delegate with Dr. Izumi as alternate.

The Council discussed how many people should be sent to the AMA conventions during the year. Mrs. Bennett explained that the proposed budget has been compiled in conference with Dr. Chung-Hoon and Dr. Hill. The sum of \$2,375.00 had been set up for AMA conventions. This figure was arrived at in the following manner:

2 round trips to New York	.....\$676.20
	676.20
1 round trip to Houston	.....545.63
Delegate's expense—June	.....200.00
Alternate's expense—June	.....100.00
Interim expense	.....175.00

**ACTION:** On motion of Dr. Lee, seconded by Dr. Pinkerton, the Council unanimously approved the



budget item for three trips for representatives at the AMA conventions and incidental expenses as outlined in the proposed budget.

**Budget:** The Council members felt that an allowance of \$300.00 per month for a temporary replacement for Mrs. Bennett might so limit the officers that they would not be able to find a capable person and they should be allowed more leeway. They agreed to increase the item for salaries from \$6,812.50 to \$7,500.00. The allowance for taxes was increased from \$162.00 to \$187.50. This changed the total allowance for expenses from \$20,559.50 to \$21,272.50.

There is a possibility that we might realize more net income from the annual meeting than \$1,060.00 which was estimated in the budget. However, the Council felt that if the income were not sufficient to cover the salaries which must be paid for a competent person, it would be essential to draw on the reserve for this purpose.

**ACTION:** On motion of Dr. Lee, seconded by Dr. Wade, the Council unanimously approved the revised budget as attached hereto.

#### BUDGET FOR 1951 - 1952

<b>Disbursements:</b>	
Journal Expense .....	\$ 9,200.00
Auditing and Legal Fees .....	175.00
Salaries .....	7,500.00
Rent .....	900.00
Postage .....	225.00
Supplies .....	175.00
Taxes .....	187.50
Telephone and Cable .....	185.00
Travel (for president) .....	100.00
Miscellaneous .....	150.00
AMA Convention .....	2,375.00*
Medical Library .....	100.00 (plus \$1,150.00)†
	<b>\$21,272.50</b>
<b>Receipts:</b>	
Journal Advertising .....	\$ 7,450.00
Journal Subscriptions .....	2,425.00
Dues .....	9,500.00
Annual Meeting .....	1,060.00
Miscellaneous .....	90.00
Interest .....	31.00
	<b>\$20,556.00</b>

\* AMA Convention:

2 round trips to New York .....	\$676.20
	676.20
1 round trip to Houston .....	545.63
Delegate's expense—June .....	200.00
Alternate's expense—June .....	100.00
Interim expense .....	175.00

† We estimate that we will donate \$1,150.00 worth of books and journals to the Honolulu County Medical Library. The books will be received by the HAWAII MEDICAL JOURNAL from the publishers in return for reviewing these books in the Journal. The journals will be received free by extending exchange subscriptions to the HAWAII MEDICAL JOURNAL.

**Revision of By-Laws:** Dr. Hill said that no amendments to the by-laws would be presented at this annual meeting. Several suggestions have been made for revisions, including the following:

- That the president-elect be a voting member of the House of Delegates and the Council
- That the Council be abolished, and its duties be carried on by the House of Delegates
- That nominations for election be circulated to the membership two weeks in advance of annual meeting
- That the budget must be approved by the House of Delegates
- That there be a standing committee on Revision of By-Laws with staggered terms

It would be necessary to study these carefully and see how they might be fitted into the by-laws if they were considered advisable. The Council felt it wise to have all amendments carefully considered by a committee appointed for this purpose.

**ACTION:** Dr. Pinkerton moved, seconded by Dr. Tilden, that the Council recommend the House of Delegates to direct the president to appoint a

standing committee of three members with overlapping terms to serve as a Committee on Revision of the By-Laws.

**Pan Pacific Surgical Congress:** It was agreed that Dr. Hill would ask Dr. Pinkerton to report on the progress of the Pan Pacific Surgical Congress at the meeting of the membership on Saturday afternoon. Dr. Pinkerton stated that 155 mainland doctors have already expressed their intention of coming. The meetings will be held from November 12 to 17. The number of speakers has not yet been decided because there are too many who would like to be on the program. There will be representatives from China, Japan, the Philippines, Australia and Canada, as well as the United States.

There being no further business, meeting was adjourned at 9:15 p.m.

Respectfully submitted,  
I. L. TILDEN, M.D.  
Secretary

### MINUTES OF MEETING HOUSE OF DELEGATES

Friday, May 4, 1951, at 1:30 p.m.

Mabel Smyth Building, Honolulu, Hawaii

**Present:** Dr. Hill, presiding; Drs. Devereux, Shimokawa, Tilden, Chung-Hoon, Bernstein, Seymour, Amlin, Richard Chun, Uyeno, Robert Benson, Cushnie, Durant, Walsh, Samuel Yee, Dodge, Duke Cho Choy, Wiig, Kemp and Kanda; also other doctors.

The Chairman called the roll.

The following reports were presented:

County Society Reports:

Hawaii County Medical Society—Dr. Leo Bernstein  
Honolulu County Medical Society—Dr. John Devereux  
Kauai County Medical Society—Dr. Dorothy Kemp  
Maui County Medical Society—Dr. T. W. Kanda

Reports of Officers:

Secretary—Dr. I. L. Tilden  
Treasurer—Dr. Edwin K. Chung-Hoon

Committee Report:

Health Education—Dr. Samuel D. Allison

**ACTION:** It was moved by Dr. Yee that all of these reports be accepted and placed on file. The motion was seconded, and passed.

The Chairman announced that the delegates will adjourn until 9:00 o'clock tomorrow morning when the reading of reports will continue and the business of the Association will be transacted.

Respectfully submitted,  
I. L. TILDEN, M.D.  
Secretary

### SUMMARY OF ACTIVITIES OF THE HAWAII COUNTY MEDICAL SOCIETY

Pete T. Okumata, M.D., Secretary

Twelve regular monthly meetings and two special meetings were held during the fiscal year.

These programs were presented as follows:

April: "Cases of kidney pathology" by Dr. S. Mizuire.  
May: "Nuclear physics of an atomic explosion" by Dr. Rudolph Wiperman.

June: Colored sound motion pictures on "Kidney Function in Health and Kidney Function in Disease." (Eli Lilly & Co.)

July: "Carcinoma of the Stomach" by Dr. Arkell M. Vaughn.

"Cancers of the Breast" by Dr. Louis P. River. Film entitled "Self-examination of the Breast."

August: Dr. Ira Hiscock presented a report on the Health Survey of the Territory.

September: Dr. P. C. Jeans presented "Newer Concepts of Prenatal Diet and Infant and Child Nutrition."

"Common Fractures of the Extremities, and Their Management" by Dr. J. Warren White.

October: "Cortisone" by Dr. Fred I. Gilbert, Jr.

*November:* "Viruses as Etiological Agents of Cancer" by Dr. John Milford, Jr.  
*December:* Dr. Robert B. Faus spoke on "Civil Defense," "Selective Service of Medical Officers" and "HMSA."  
*January:* "Presidential Message" by Dr. Rogers Lee Hill. Report on the Third Annual Conference of the National Education Campaign of the AMA in Cleveland, Ohio, by Dr. Richard C. Durant.  
*February:* "Personal Medical Observations at Various Medical Centers of the United States" by Dr. Sam R. Brown.

An amendment to the Constitution and By-Laws, increasing the annual dues \$10.00 from \$40.00 to \$50.00, was passed.

The Society financed the renovation of the staff room of the Hilo Memorial Hospital.

The Hawaii Territorial Medical Association Convention was held in Hilo, with Hawaii County Medical Society as host. The entertainment of the visiting Auxiliary by the local Auxiliary, was financed by this Society.

The Society appropriated \$250.00 for flowers to be sent to the AMA Convention in San Francisco.

The Disaster Council for the year was composed of Drs. Orenstein, Crawford, Wipperman, Carter and Seymour.

The Society went on record to approve the fluoridation of the Hilo Water Supply.

A resolution to maintain the Veterans' Administration office in Hilo was sent to the Veterans' Administration in Washington, D. C., and to Delegate Joseph R. Farrington.

The Society encouraged the HMSA membership drive in Hilo.

New members admitted are Drs. Kay K. Ota, William G. Gaenge, Jr., Fred I. Gilbert, Jr., Hoei Higa and Richard Neil.

Dr. Marion L. Hanlon transferred from Honolulu to the Hawaii County Medical Society.

Drs. Wah Tim Chock and H. W. Kurashige resigned. Dr. Fred I. Gilbert, Jr., returned to his instructorship at Stanford University School of Medicine.

Drs. Donald Depp and K. Yoshimura transferred to the Honolulu County Medical Society.

Dr. John J. Milford, Jr., passed away.

The annual meeting was held at the Hilo Country Club on March 24, 1951. Dr. Leo Bernstein was given a vote of thanks for his excellent work as President during the year.

## **SUMMARY OF ACTIVITIES OF THE HONOLULU COUNTY MEDICAL SOCIETY**

**William S. Ito, M.D., Secretary**

Honolulu County Medical Society Public Service Committee, represented by three of its members, personally participated in the Cleveland meeting of the Third Annual Conference of the AMA's National Education Campaign, thus creating considerable interest in the problems of Hawaii. This group, along with the Territorial Delegate to the AMA, presented at the Interim Session of the AMA, the Hill-Cherry outline on "Burn Therapy," which was received as an outstanding document in the treatment of burns.

The Public Service Committee brought to Honolulu the first public opinion poll of medicine in the Territory of Hawaii.

Much has been done on the part of the Preparedness Committee to coordinate plans for civil defense, the assignment of doctors to aid stations and to the hos-

pitals and Blood Bank, and the consideration of deferment requests for physicians in hospitals to selective service and the armed services.

Physicians assigned to First Aid Stations, under the direction of Dr. H. S. Dickson, are conducting first aid classes weekly to lay communities.

Over 200 physicians attended the special training course in over-all effects of atomic bursts.

Outstanding postgraduate lectures were presented by Dr. Alfred Blalock of Baltimore and Dr. Paul White of Boston.

The Advisory Group to the Subcommittee on Hospitals, Medical Care, Health and Welfare of the Hold-over Committee of the Legislature, has been active in the study of important community health needs.

The Public Service Committee and the Nursing Service Bureau are to launch on a trial basis, a medical emergency call service.

The execution of a new contract between the HMSA and the Medical Society, will probably be completed within the near future. It is proposed to execute a primary contract between the Medical Society and the HMSA, and individual agreements between the doctors and the Society.

Dr. Samuel Yee, the immediate past president, recommended the review and evaluation of the data of the Public Opinion Survey, and that specific recommendations be made to the Society therefrom.

## **SUMMARY OF ACTIVITIES OF THE KAUAI COUNTY MEDICAL SOCIETY**

**Keith Kuhlman, M.D., Secretary**

The Kauai County Medical Society holds its monthly meetings at the G. N. Wilcox Memorial Hospital Library, Lihue, Kauai, on the second Wednesday of each month at 7:30 p.m.

### *Personnel:*

1. Dr. D. Chisholm resigned from his duties at Mahelona Hospital, and was replaced by his former assistant, Dr. Peter Kim. Dr. Gordon Liu has joined Dr. Kim at Mahelona and will be Dr. Kim's assistant in medical affairs.

2. Dr. G. Bieber has left Kilauea Plantation for an obstetrical and gynecological residency on the mainland. His position at Kilauea is still vacant, awaiting a replacement.

3. Dr. N. Steuermann will be leaving Kauai for the position of Plantation Physician at Olaa, Hawaii.

4. Dr. F. Sykes joined the staff at Wilcox Memorial Hospital as resident physician in July of 1950. Dr. Sykes is a graduate of the Medical College of Virginia, and served his internship at Sparrow Hospital, Lansing, Michigan.

### *Activities:*

1. The Society moved to support the Hawaii Visitors Bureau in the March meeting of 1950, with individual contributions.

2. At the April meeting it was voted to accept the application of Dr. D. Kemp for membership. Dr. Faus spoke to the members on the financial problems facing the HMSA.

3. At the May meeting Dr. Kemp gave a report on the Hawaii Territorial Medical Association Meeting at Hilo. Dr. Blalock, prominent cardiac surgeon, was guest speaker.

4. The Society was informed in its June meeting, that the Hawaii Territorial Medical Association had



approved a \$25.00 assessment by the AMA for public relations. It was also voted to support the Cardiac Clinic of the Hawaii Heart Association, to be conducted by Dr. J. Bell, on August 16. Dr. White, eminent cardiologist, then addressed the Society on various cardiac diseases.

5. The Society voted to operate as a part of the Honolulu Blood Bank, a blood service. This marked the first time that a blood bank service would be available to the people of Kauai. Dr. Steuermann's application for membership was approved.

6. At the August meeting the Society voted to support the present Workmen's Compensation Law. A grievance committee, composed of Drs. Wade, Masunaga and Wallis, was appointed to handle disputed problems between the physicians and the HMSA. Dr. Kemp was appointed Medical Director for Kauai, to the Territorial Major Disaster Council.

7. Action on the appointment of a Committee on Hospital and Professional Relations was postponed.

8. The November meeting was cancelled due to the Plantation Physicians' Territorial Association meeting on November 10, 11 and 12. This meeting was well attended and highlighted by several interesting papers by Drs. Strode, Patterson, Sakimoto, F. Lam, Jr., Peyton, Johnson and Col. Charles L. Leedham. A panel discussion on Industrial Accidents by Mr. William Douglas, Mr. Chester Frowe, and Drs. Boyden, Carter, Toney, Johnson and J. W. White, was well received.

The problem of increasing the stipend for Government Physicians, or operating welfare service on a fee service basis, was discussed among the Plantation Physicians and Dr. Lee of the Public Health Service. It was decided to approach this problem on a local basis, each Society rendering its recommendations individually.

9. It was the unanimous opinion of the members of the Kauai County Medical Society, that medical examinations of all new civil service employees, and periodical examinations of all permanent employees, be operated on a "fee for service" basis, with a free choice of physician to the patient. Dr. B. Wade was made Chairman of the Advisory Committee on the selection of doctors and allied specialists, and Dr. J. Kuhns, a member of this Board.

10. At the December meeting Dr. Wallis was appointed to represent the Society in the Honolulu Cancer Society.

11. The County Society went on record as endorsing a program of government support for the Bureau of Nutrition. Dr. R. L. Hill on his presidential visit, addressed the Society in reference to supporting the AMA program. Dr. Nishigaya gave a report on the AMA Public Relations Delegates Conference in Cleveland, Ohio.

12. Election of officers was held at the March 14 meeting.

## SUMMARY OF ACTIVITIES OF THE MAUI COUNTY MEDICAL SOCIETY

Edward T. Shimokawa, M.D., Secretary

The Maui County Medical Society for the year, March 1950 - March 1951, had twelve meetings, of which five were business meetings, three were business and scientific meetings, and four were scientific meetings. The guest speakers on the programs, in the order of their appearances, were as follows:

1. Dr. R. B. Faus—HMSA Program
2. Dr. Paul D. White of Harvard—Cardio-vascular diseases
3. Dr. Dorian Paskowitz—Incidence of Cancer in Hawaii

4. Dr. P. C. Jeans of Iowa—Infant Nutrition
5. Dr. R. L. Hill—Presidential Message
6. Dr. Isaac A. Kawasaki—Highlights of the Cleveland Meeting of AMA
7. Dr. R. B. Faus—Territorial Disaster Plan
8. Colonel Charles L. Leedham, USA of Tripler Hospital—Rheumatic Fever
9. "Course on Medical Aspects of Atomic Explosions"—presented by a team of twelve members from the Territorial Disaster Relief Agency, Dr. R. B. Faus, Chairman.
10. Dr. Thomas Fujiwara—Clinical Hematology
11. Dr. Harold Cuij—Clinical Pathology

In addition, Dr. J. F. Ferkany of Kula presented "Cancer of the Lungs."

### Membership:

At the end of the preceding year, March 1949 - March 1950, the membership consisted of 29 active members.

During the year the Society lost two members by resignation—Dr. Elmer C. Johnson and Dr. Joseph E. Molloy—and gained one member, Dr. Jesse I. Knox, Jr.

There are at present three non-affiliated physicians on Maui—Dr. V. Voids of Kula, Maui, Dr. T. G. Lathrop of Wailuku, Maui, and Dr. E. J. Meuli of Maunaloa, Molokai.

The two honorary members are Dr. William T. Dunn of Lahaina, Maui, and Dr. Gordon H. Lightner of Upperville, Virginia.

At the end of this year, March 1950 - March 1951, there was a total of twenty-eight active members in the Society.

### Activities:

1. The Society endorsed and supported the Maui Chamber of Commerce Program pertaining to the Maui County Health Officer. This was accomplished by the end of the year with the appointment of Dr. T. G. Lathrop of the State of Washington, by the Territorial Board of Health.

2. The question of the establishment of a Heart Clinic at Puunene Hospital, as proposed by the Hawaii Heart Association, met some opposition but was finally approved, and a Clinic was held assisting physicians in the care of heart diseases.

3. The Society agreed to obtain a resident pathologist for Maui, through the cooperation and financial support of the Maui Cancer Society. A committee chair-manned by Dr. Frank St. Sure, Jr., is at present formulating plans for selecting a qualified pathologist.

4. Because the proposed change in the Workmen's Compensation Act transferring "free choice of physicians from employer to the patient" did not involve our local set-up, the majority of the members felt that at present no action on the question was necessary.

5. The Society actively participated in the ground breaking ceremony of the Central Maui Memorial Hospital in Wailuku, Maui, on August 20, 1950.

6. The Society cooperated with the Maui Chapter of the National Foundation for Infantile Paralysis, on the selection of a Maui candidate for scholarship on physical therapy.

7. The County Advisory Committee Chairman, Dr. John Sanders, met with the local legislators several times during the year to study and discuss pending medical legislations.

8. In general, a year of varied and interesting activities occupied the attention of the Society. The Society has at all times cooperated fully with other local organizations in numerous community projects pertaining to health, medical care and related matters. The Society is especially grateful to the Woman's Auxiliary for the splendid job of entertaining the guests of the Society during the year.

**REPORT OF THE SECRETARY****I. L. Tilden, M.D.**

The total membership of the Association in all classes is 529, of which 380 (1 more than last year) are paid regular members. By counties this membership is made up as follows:

	REGULAR MEMBERS	ASSOCIATE MEMBERS	RETIRED MEMBERS	LIFE MEMBERS	HONORARY MEMBERS	TOTAL ALL CLASSES
Hawaii .....	41	—	—	—	3	44
Honolulu .....	298	116	4	9	15	442
Kauai .....	13	—	—	—	—	13
Maui .....	28	—	—	—	2	30
	380	116	4	9	20	529

The total number of physicians licensed to practice medicine in the Territory of Hawaii as of January 31, 1951, is 562. Of this number 458 are now residing in the Territory. Of these, 427 or approximately 93 per cent, belong to the Hawaii Territorial Medical Association.

**REPORT OF THE TREASURER****E. K. Chung-Hoon, M.D.**

The Hawaii Territorial Medical Association began its fiscal year on March 1, 1950, with a cash balance of \$10,407.92. This sum reflects a savings account of \$3,052.95, a checking account of \$7,304.97, and a petty cash fund of \$50.00. Our income during the past year was \$20,404.85, and our expenses totaled \$20,401.00. We realized a net gain of \$3.85. As of March 1, 1951, the Association's cash balance is \$10,411.77.

A review of the expenditures shows that a close parallel was maintained with the budget. This required wise and judicial management on the part of our executive staff. The major part of our income is derived from membership dues and from the HAWAII MEDICAL JOURNAL. The major portion of our expenses is in salaries and cost of publication of the JOURNAL.

In my report to you in 1950, I recommended that the Hawaii Territorial Medical Association provide in its annual budget sufficient funds to defray the expenses of its delegates to the AMA convention. This was approved. I have again included in the budget, for your approval, a sum of money to help defray the expenses of our delegates. This sum includes the expenses of the delegate and his alternate to the June convention in Atlantic City, and for the delegate or his alternate to the interim session. Our delegate is expected to properly represent the Hawaii Territorial Medical Association at the AMA convention, and is required to submit a report of the transactions of that convention to this Association. In my opinion, therefore, his expenses should be paid from Association funds, and not from any other source. The sum included in the budget for this purpose is reasonable but barely adequate.

In the past it has been mandated that our executive secretary, upon the order of the Chairman of the Public Service Committee, sign checks for the disbursement of funds of that committee. Public Service Committee funds are funds of this Association, and duly authorized disbursement of them would fall within the duties of your treasurer. Since our executive secretary will be on vacation and extended leave of absence for approximately eight months, it is recommended that the treasurer, or in his absence the secretary, be authorized to

sign the checks of the Public Service Committee upon the order of its chairman henceforth.

The disbursements for the year are as follows:

JOURNAL Costs .....	\$ 9,099.38	
Auditing .....	75.00	
Burn Therapy .....	59.35	
Miscellaneous .....	54.90	
Postage .....	224.36	
Rent .....	900.00	
Salaries .....	7,538.75	
Supplies .....	169.75	
Taxes .....	97.73	
Telephone and Cables.....	166.25	
Travel .....	54.32	
American Medical Assn. Convention.....	1,761.20	
Donations .....	200.00	\$20,401.00

The accounts have been audited and found to be in good condition. The auditor's report is attached hereto.

I wish to express my sincere thanks and appreciation to our executive secretary, Mrs. Edith Bennett, who through her several years of work, has given unstintingly of her time and effort in our behalf, not only as the Association's Executive Secretary, but also as Managing Editor of the HAWAII MEDICAL JOURNAL. This office extends its best wishes to Mrs. Bennett as she leaves on an extended vacation.

It is an honor and a privilege to have served as your treasurer.

**REPORT OF THE HEALTH EDUCATION COMMITTEE****S. D. Allison, M.D., Chairman**

It is my pleasure to submit the following report concerning the activities of your Health Education Committee during the year 1950-51.

This Committee for the past few years was headed by Dr. Marie Faus, who did an admirable job, particularly with reference to health education through the medium of the radio. In accordance with your suggestions to broaden both the membership and scope of activities of the committee, and in the absence of any funds with which to work, your Committee has felt that its function should be primarily exploratory, and that subsequent committees might further expand certain suggested activities.

Prior to the development of a committee, communications were addressed to several voluntary and official health agencies, inviting their opinions as to the role the Medical Association should play in health education. Numerous suggestions were received. Letters were written to a score of physicians, selected at random, asking their opinions as to the activities their committee should pursue. Following your recommendations and the suggestions received from the membership at large, and to assure representation from individual practitioners and groups, specialists and general practitioners, races, sexes, urban and rural viewpoints, the following physicians were asked to serve:

T. Alan Casey  
Thomas Y. K. Chang  
Duke Cho Choy  
Charlotte Florine  
Tadao Hata  
Tell Nelson

These members served effectively and well. I should like personally to thank each of them. In addition to the members of the committee, we were fortunate to have the help of Mrs. Bennett, who met with us often and represented us in certain outside activities.



The committee met over a dozen times, at first discussing the suggestions received from representative physicians and agencies, and later exploring new fields of activity. It was early concluded that some areas of health education are being covered inadequately; that this year we could best serve as an investigating committee; that in most cases we could serve best through existing agencies, but that our work might be materially augmented through the aid of our Auxiliary.

To better determine our relationship with other official and non-official health and education agencies, special studies were carried out by committee members, and meetings were held with various agency representatives. Dr. Hata explored the activities of the Health Coordinators of the schools. Dr. Casey surveyed doctor participation in the PTA. Dr. Nelson met frequently with the Exhibit Committee of the Oahu Health Council and participated in their planning for the 49th State Fair. Dr. Chang reviewed the health services of a large public school. The entire Committee met with Mr. Tate Robinson of the Department of Public Instruction, Miss June Johnson of Farrington High School, Mrs. Moses Ome of the PTA, and Mrs. F. J. Halford, President of our Auxiliary. The Committee activities were integrated with the Research and Resources Committee of the D.P.I.—Board of Health by Dr. Choy, the Health Education Council by Mrs. Bennett, and the Honolulu County Medical Society's Public Relations Committee by Dr. Allison.

Considerable time was devoted to discussion of the role of health education in the public schools. We believe that too little time is devoted to health education, and that the teaching of health, however good in a few places, leaves much to be desired. It is the sense of the Committee that health should be taught regularly and well in all schools, and that adequate resources should be provided to the Department of Public Instruction to make this possible. To effect good teaching of health, it is believed that this phase of teacher training at the University of Hawaii Teachers' College should be expanded. These problems are continuing ones, and are suggested as suitable for further study by our Association. Our help will likely be required in obtaining adequate legislative and financial support for good health teaching.

During the year numerous references appeared in the Journal of the AMA, as to school health committees of medical societies. Our committee explored this subject in detail, and came to the conclusion that for the present Hawaii should not establish a separate School Health Committee, but that these activities should be carried on by the Health Education Committee. There is great need for closer liaison between the Medical Association and the Department of Public Instruction.

Dr. Maurice DeHarne called the attention of the Committee to the desirability of using the public school system as a means of first aid teaching. This matter was explored by Dr. Hata, who met with numerous representative governmental health, education and disaster relief agencies. Dr. Nelson investigated the teaching of first aid through the ROTC. The Committee decided that the promotion of this activity is not logically one of ours, but that of the Territorial Disaster Relief Agency. Consequently, representation was requested and granted on the Public Education Committee of the Disaster Relief Agency.

Through the Health Educators' Council, pamphlet racks are being made available without cost, for use in

physicians' offices. The Auxiliary has been asked to establish a project for distributing these racks, and keeping them filled with health material of the doctor's choice.

There is a mass of radio material available for use. It was the sense of the Committee that the arrangement for the distribution of this material might well be a function of the Auxiliary. Mrs. Halford, President of the Auxiliary, was approached regarding this and appointed a committee headed by Mrs. Garton Wall, to arrange for the use of the material. The Auxiliary has taken on this project along with that of pamphlet distribution. Your committee recommends that further requests be made of the Auxiliary in the fields of Health Education. It can well be done by them, they have more available time for such activities than their physician husbands have, they can represent the Association's viewpoint, and can provide greater anonymity of the physicians in the picture.

This committee would like to suggest a few items for your consideration. Although a need for funds was not experienced by this year's committee, health education by the Association could be much more effective if some funds were made available for specific projects. We believe that a few of the present committee members should be carried over to next year in order to provide continuity of action. However, it is also believed that many physicians should ultimately have the privilege of serving on this committee. Further aid should be sought from the Auxiliary. One particular phase of action that needs constant study is that of school health education. A continued attempt should be made to revitalize an adequate and uniform school health education program, and as a means to this end we should cooperate with all interested agencies.

## MINUTES OF MEETING HOUSE OF DELEGATES

Saturday, May 5, 1951 at 9:00 a.m.

Mabel Smyth Building, Honolulu, T. H.

*Present:* Dr. Rogers Lee Hill, presiding; Drs. Edward T. Shimokawa (Maui), I. L. Tilden, Edwin Chung-Hoon, Leo Bernstein (Hawaii), Walter J. Seymour (Hawaii), Kenneth Amlin, Richard Chun, David Pang, Raymond Uyeno, Robert Benson, Edward F. Cushnie, Richard C. Durant, William M. Walsh, Samuel L. Yee, Richard Dodge, Marquis Stevens, Barney Iwanaga, Dorothy Kemp (Kauai), John A. Burden (Maui) and T. W. Kanda (Maui).

*Reports:* On motion of Dr. Amlin, duly seconded, the delegates voted to dispense with the reading of reports until after the business meeting.

*Next Annual Meeting:* On motion of Dr. Yee, seconded by Dr. Chun, the date for the next annual meeting was set for May 1, 2, 3, 4, 1952, in Honolulu, with a registration fee of \$10.00.

*Resolutions:* On motion of Dr. Durant, seconded by Dr. Stevens, the following resolution was adopted:

WHEREAS, Dr. Guy Champion Milnor practiced medicine in Honolulu from 1914 to 1950, and during this time achieved an outstanding reputation in his chosen field of obstetrics and gynecology; and

WHEREAS, during this time he was honored by election to the presidency of the Honolulu County Medical Society in 1926, and to the presidency of the Howoii Territorial Medical Association in 1935; and

WHEREAS, Dr. Guy Champion Milnor took an active and constructive part in the affairs of his community; and

WHEREAS, Dr. Milnor died after a brief illness, on October 26, 1950; now therefore be it

**RESOLVED**, that the esteem in which he was held, and the affection with which he was regarded by the Members of the Hawaii Territorial Medical Association, together with the members' deep sense of loss at his untimely demise, be here expressed; and be it further **RESOLVED**, that a copy of this resolution be spread upon the minutes of the Association; and be it further **RESOLVED**, that copies of this resolution be transmitted to his wife, Mrs. Nell Poersel Milnor, and to his son, Dr. John Milnor.

Rogers Lee Hill, M.D., President  
I. L. Tilden, M.D., Secretary

On motion of Dr. Durant, seconded by Dr. Amlin, the following resolution was adopted:

**WHEREAS**, Dr. John Milford has been a conscientious general practitioner of medicine and surgery both in Honolulu and on the Island of Hawaii for the past 2½ years, and has gained the confidence and goodwill of his many patients; and

**WHEREAS**, he was a member of the Hawaii Medical Society and the Hawaii Territorial Medical Association; now therefore

**BE IT RESOLVED**, that the members of the Hawaii Territorial Medical Association do hereby express their sincerely felt sense of loss at his untimely death; and be it further

**RESOLVED**, that a copy of this resolution, signed by the President and Secretary of the Society, be sent to Mrs. Milford, spread upon the minutes of this Association, and published in the *Hawaii Medical Journal*.

Dr. Walsh presented the following resolution:

For reasons which may have been logical and valid at the time, the American College of Surgeons 35 years ago assumed the responsibility for the evaluation and standardization of medical practice in hospitals.

At that time the American Medical Association had but recently established its council on medical education and hospitals. It would have seemed that the logical body to undertake hospital standardization was this agency of the AMA, but the task was assumed by the American College of Surgeons. Though some of the reasons for this have been lost in the erosion of history, others will be readily apparent. Modern surgery was then less than fifty years old. The majority of hospitalized patients were surgical cases. The bulk of medical cases was cared for in the patient's home, and only in recent years have beds in medical and obstetrical wards exceeded the number in the surgical ward of the typical general hospital. Elevation and standardization of surgical practice was then a crying need.

However, more recently conditions have changed. Today the internist, the obstetrician, the psychiatrist, the general practitioner, and all other special groups have interests equal to those of the surgeons in maintaining proper standards and safeguards in the hospital. Therefore, it is not surprising that in the past few years proposals in the House of Delegates in the AMA have been introduced that the entire responsibility for the evaluation and standardization of medical practice in hospitals, be assumed by its council on medical education and hospitals.

Due to the large expenditure of money on hospital standardization programs, the American College of Surgeons came to the decision early last spring, that the responsibility of financing the program should be assumed by some other more widely representative body.

So it happened that the House of Delegates of the American Hospital Association at its annual meeting last fall, leaped into action and without further ado, instructed its Board of Trustees to assume, direct and take over this program, and ordered increased dues to finance the work. And in addition to this, employed Dr. Malcolm T. MacEachern who had directed the American College of Surgeons' hospitalization program for many years, but who had recently been retired. Obviously, the American Hospital Association was prepared to assume full control of hospital standards. As one hospital journal puts it, "He who pays the fiddler will call the tune."

So in the face of strong objection to the approval of medical standards in hospitals by a lay body, the House of Delegates of the AMA at its interim meeting last December, discussed a proposal for the creation of a committee of 24 to supervise and direct a program of hospital standardization; the committee to consist of eight members of the AMA, eight from the AHA, four from the ACS, and four from the ACP. It was pointed out later, however, that the council on medical education and hospitals of the AMA was equipped with both personnel and experience, to assume the program and that indeed, much of its activity in the field of intern and residency program approval, overlapped the activities presently conducted by the ACS. However, for some inexplicable reason, the ACS was unwilling to turn this program over to the AMA.

On March 26, 1951, Dr. George F. Lull, Secretary of AMA, announced that agreement had been reached by the four major organizations interested in assuming this authority—the AMA, the AHA, the ACS and the ACP. But since the conclusions will have to be presented for approval by all of the parent bodies, it is doubted that the new program will ever come to pass, and if so, not for at least one year. This tentative agreement was reached at the sixth of a series of turbulent conferences that started one year ago.

Several of the independent organizations have enacted resolutions stating that the American Medical Association, alone representative of all branches of the medical profession in America, was the proper and logical body to assume control of professional standards in hospitals, and that this function be assumed by the Council on Medical Education and Hospitals.

Being fully informed of the entire situation, it is my belief and the belief of the AMA House of Delegates and the American Academy of

General Practice House of Delegates, that the control of medical practice in hospitals should rest solely in the one all-inclusive organization in which all branches of the profession have a voice, the American Medical Association.

Thus, I offer this resolution for the approval of our House of Delegates here today, to the effect that we instruct our delegate to the AMA House of Delegates to present this resolution to the floor as the opinion of the Hawaii Territorial Medical Association:

**WHEREAS**, the evaluation and standardization of medical practice in hospitals is of such paramount importance to all branches of the medical profession, that it should be under the sole and complete authority of the American Medical Association, which is the only medical organization representative of the entire profession in America, and in which all segments of the profession have official democratic means for expressing their views on matters of such importance as the control of hospital medical practice.

**BE IT THEREFORE RESOLVED**: that regardless of what other organizations may undertake in connection with the standardization of non-professional matters, control of medical practice in hospitals should be vested in the Council on Medical Education and Hospitals of the American Medical Association.

**ACTION**: On motion of Dr. Tilden, seconded by Dr. Amlin, the resolution was adopted.

*Eligibility to Vote for AMA Delegate*: Dr. Hill announced that any decision reached on this matter at this meeting would not apply to today's election, but would apply to later elections. Dr. Arnold, Jr., stated that he felt it was clear that if any member relinquished his membership in the AMA, he naturally could not expect to have a vote in that organization.

**ACTION**: On motion of Dr. Yee, duly seconded, it was agreed that eligibility to vote for AMA delegate and alternate, be contingent upon payment of the \$25.00 AMA dues.

*Fellowship, AMA*: Dr. Walsh stated that he was in favor of eliminating Fellowship status in the AMA, and according to AMA members all privileges now reserved for Fellows, and that he believed the AMA should drop the expression "Fellow" as being antiquated and obsolete.

**ACTION**: On motion of Dr. Walsh, seconded by Dr. Amlin, the delegates voted to instruct our delegate to the AMA to do everything possible to persuade the AMA to abolish Fellowship, and to grant to members the privileges formerly reserved for Fellows.

*Council*: The minutes of the Council meeting of May 3 were read by the President and circulated to the delegates.

*Revision of By-Laws*: The Council had recommended to the House of Delegates that a standing committee be appointed for the revision of the by-laws, and that the membership of this committee be staggered. It was understood that the recommendations of this committee are to be brought before the delegates, and then become mandatory.

**ACTION**: On motion of Dr. Kemp, seconded by Dr. Nance, the delegates agreed to request the president to appoint a standing committee for the revision of the by-laws, with staggered terms of membership.

*Budget*: The delegates discussed the need for sending both a delegate and an alternate to the AMA, in view of the limited finances of the Association. After due consideration the delegates deemed it advisable to accept the item in the budget in which the Council provided funds to send both the delegate and the alternate to the June meeting of the AMA, and to send one representative to the interim session at Houston, Texas.



**ACTION: Dr. Nonce moved, seconded by Dr. Burden, that the delegates approve the budget as presented by the Council.**

Dr. Yee pointed out that the Honolulu County Medical Society assumes a large part of the Territorial expenses, and that the Honolulu County Medical Society is trying very hard to budget its expenses to keep within its income. He felt that the Territory's budget should be scrutinized carefully, because if the Honolulu County Medical Society went into debt, the Territorial Association would suffer. He felt that serious consideration should be given to the budget in relation to the component societies.

**ACTION: Dr. Amlin moved that the motion to approve the budget be tabled until after the election of the delegate and the alternate to the AMA. This motion was seconded by Dr. Chung-Hoon and carried.**

*Election of Delegate and Alternate:* The Chairman announced that the Nominating Committee had nominated Dr. Homer Izumi as delegate. Dr. Durant stated that in accordance with a motion passed by the Honolulu County Medical Society Board of Governors, he nominated Dr. Hartwell as delegate to AMA. There was some discussion on this point.

**ACTION: Dr. Yee moved that the nominations for delegate be closed. The motion was seconded and passed. The vote was by secret ballot, and Dr. Hartwell was elected as delegate to the AMA.**

On motion of Dr. Durant, the secretary was instructed to cast an unanimous ballot for Dr. Izumi as alternate delegate. The motion was seconded and passed.

Dr. Amlin moved that Dr. Izumi's trip to the AMA be eliminated from the budget for 1951 and 1952. The motion died for want of a second.

**ACTION: Dr. Bernstein moved approval of the budget as presented by the Council. The motion was seconded and passed.**

**ACTION: Dr. Chung-Hoon moved that the Council report be approved. This was seconded by Dr. Bernstein, and passed.**

*Committee Reports:* The following reports were read, accepted and placed on file:

- a. Cancer—Dr. Grover A. Batten
- b. Advisory Council, Woman's Auxiliary—Dr. T. H. Richert
- c. Psychiatry—Dr. William H. Stevens
- d. Board of Management, Mabel Smyth Building—Dr. Rodney West
- e. By-Laws—Dr. Samuel L. Yee
- f. Postgraduate—Dr. Verne C. Waite
- g. Legislation—Dr. Harry L. Arnold, Jr.
- h. Journal—Dr. Harry L. Arnold, Jr.
- i. Public Service—Dr. Richard C. Durant
- j. Preparedness—Dr. Robert B. Faus
- k. Advisory Committee to Bureau of Crippled Children—Dr. T. A. Casey
- l. Advisory Committee to Bureau of Maternal Health and Child Health—Dr. H. M. Patterson

In connection with the Postgraduate Committee report, Dr. Burden said that the Maui doctors have strongly urged that more Honolulu doctors should come over and give the Maui doctors the benefit of their experience. Dr. Seymour stated that the Honolulu County postgraduate lecture series is fine for the Honolulu doctors, but it is practically impossible for the other Island doctors to attend because they cannot manage to be away from their practices for such long periods. If the doctors from the other Islands could come to Honolulu for two or three days of concentrated lectures, they could arrange to stay away for such a period.

Dr. Bernstein stated that the doctors on the other Islands need to have longer notice that there is a speaker available to come to the other Islands. Dr. Kemp stated that the Kauai doctors agreed. Dr. Waite said that had been one of the difficulties in the past because we could seldom determine what a visiting doctor's plans would be.

In connection with the report of the HAWAII MEDICAL JOURNAL, the delegates mentioned that Dr. Arnold, Jr. is deserving of great credit for the fine journal which is published here in Hawaii through his efforts. Dr. Lee also added that all through the legislative ses-

sions here, Dr. Arnold had made numerous appearances at committee hearings. He felt that the Territorial Medical Association had been ably represented by Dr. Arnold.

**ACTION: On motion of Dr. Yee, duly seconded, the House of Delegates extended a vote of thanks to Dr. Arnold for his services, and expressed the hope that he would continue so to serve in the future.**

**ACTION: In relation to the report of the Advisory Committee to the Bureau of Crippled Children, Dr. Walsh moved that the delegates instruct this committee to investigate the reasons why the Bureau of Crippled Children permits only Specialty Board diplomates to take care of their patients, and why they have some non-diplomates on their committee, and report to the Association next year. The motion was seconded by Dr. Kemp and passed. Dr. Bernstein said the doctors do not have to be certified by the Board, but must be eligible for Board certification. Dr. Kemp said this is a Federal restriction, and we have no power to change it.**

Dr. Cushnie raised a question as to why the funds for the Bureau of Crippled Children should be increased, and stated that the doctors did not know enough about the needs to vote on this point. Dr. Bernstein said figures had been presented by the Board of Health to the Advisory Committee to show the need for care for those who are not receiving it now. Dr. Kemp said that two years ago, through a typographical error by a clerk in the Legislature, the appropriation for the Bureau of Crippled Children for the biennium, was \$75,000.00, instead of \$125,000.00.

**ACTION: After this discussion of the Bureau of Crippled Children's report, Dr. Tilden moved that the delegates accept the report of the Advisory Committee to the Bureau of Crippled Children, and approve its recommendation. The motion was seconded by Dr. Stevens, and passed.**

In relation to the report of the Advisory Committee to the Bureau of Maternal & Child Health, the question was raised concerning the implementation of the first recommendation. The doctors stated they were in favor of having all obstetrical patients submit to blood grouping and Rh typing, but they wanted to know whether this was to be enforced by law, or how it was to be done.

**ACTION: On motion of Dr. Walsh, seconded by Dr. Durant, the House of Delegates changed the wording of the first recommendation of this report to read as follows: "that the Bureau of Maternal & Child Health circularize all physicians in Hawaii, recommending that all obstetrical patients should have blood grouping and Rh typing done when they first seek prenatal care."**

*Election:* Dr. Hill said that he first expected to do away with the Nominating Committee entirely, but due to certain qualifications applying to the positions of delegate and alternate, it is almost necessary to screen candidates for these positions. It was principally for the delegate that the Nominating Committee was appointed. It was considered desirable to circulate the nominations so that everyone might express an opinion to his delegate.

The Chairman announced that the following nominations had been submitted by Dr. Trexler, chairman of the Nominating Committee:

Council (two to be elected):

Dr. William Ito  
Dr. Paul Gebauer  
Dr. Henry Gotshalk

The Chairman called for nominations from the floor. Dr. Chung-Hoon nominated Dr. Cushnie. On motion of Dr. Benson, seconded by Dr. Walsh, the nominations were closed.

When it was pointed out that the by-laws provide that no doctor may serve as both a delegate and a member of the Council, Dr. Cushnie withdrew. The delegates voted by secret ballot, with Dr. Arnold, Jr., as teller. The results were as follows:

Dr. Ito .....12  
Dr. Gebauer .....11  
Dr. Gotshalk .....11

The Chairman declared that Dr. Ito was elected, and that another ballot would be taken to determine the tie between Dr. Gotshalk and Dr. Gebauer. The result of this ballot was as follows:

Dr. Gotshalk .....11  
Dr. Gebauer .....6

The Chairman declared that Dr. Gotshalk had been elected.

The Nominating Committee had nominated Dr. John Sanders and Dr. Edmund Tompkins for President-elect (one to be elected).

Maui County had submitted the names of three Maui doctors to the Chairman of the Nominating Committee, and Dr. Burden said that the Maui Society had been well satisfied with the names submitted from Maui.

Dr. Benson nominated Dr. McArthur; Dr. Tilden nominated Dr. Burden. Dr. Burden stated that he felt he did not have sufficient time to devote to the job, but he did not withdraw his name from nomination. Dr. Kanda moved that the nominations be closed. The motion was seconded by Dr. Seymour, and passed.

The vote by secret ballot was as follows:

Dr. McArthur .....11  
Dr. Tompkins .....4  
Dr. Burden .....2  
Dr. Sanders .....0

On motion of Dr. Yee, seconded by Dr. Chung-Hoon, the secretary was instructed to cast an unanimous ballot for Dr. McArthur as President-elect.

There being no further business, the meeting was adjourned.

Respectfully submitted,  
I. L. TILDEN, M.D.  
Secretary

REPORT OF THE CANCER COMMITTEE

Grover A. Batten, M.D., Chairman

The Cancer Committee is pleased to make the following report of its activities during the past year. This year, as in the past years, there has been very close co-operation between the Territorial Medical Association, the Hawaii Cancer Society and the Department of Health. The slogan "Every Doctor's Office a Cancer Detection Center," is being more and more realized by the three organizations mentioned above as well as the community as a whole. The following services in the field of cancer control have been sponsored by the Territorial Medical Association, the Hawaii Cancer Society, and the Territorial Department of Health.

Public Education—A new film prepared jointly by the American Cancer Society and the National Cancer Institute, called "Breast Self-Examination," has been widely used throughout the entire Territory during the past six months. The film was formally approved by the Territorial Medical Association and each of the county societies. Physicians throughout the Territory participated extensively as speak-

ers who accompanied the showing of this film. On Oahu alone, there have been 150 separate showings of this film, with a total attendance of approximately 6,000 people. A doctor accompanied the film as a speaker at 50 of these showings. Every effort is being made to emphasize the hopeful aspects of cancer in all education programs.

Professional Services—The Cancer Bulletin has been distributed to practically all physicians in the Territory. A survey was recently made to determine the number of physicians who were reading the Bulletin. Replies were received from 190 doctors. 131 said that they always read the Bulletin; 178 said that they wish to continue receiving the Bulletin. The survey also indicated a wide spread interest among physicians in postgraduate courses in various fields of cancer control. No one was brought to the Territory during the past year for this purpose. A number of doctors were in Honolulu for other reasons, and were utilized as speakers on cancer before professional groups.

Medical Services—Statistics on the services rendered by the cytologic laboratory which is operated by the Hawaii Cancer Society, were compiled for the first eighteen months of operation (July 25, 1949-December 31, 1950). 6,225 slides were examined for a total of 3,242 patients. 41 positive slides were found. 33 of the positive slides were vaginal smears, one was sputum, one breast secretion, one urinary, two pleural fluid, one ascitic fluid, and three miscellaneous. The slides were examined by a trained laboratory technician, and all suspicious slides were referred to a committee of physicians with special training in this field. 194 doctors scattered throughout the entire Territory participated in this service.

A committee composed of representatives from the Hawaii Territorial Medical Association, the Hawaii Cancer Society and the Bureau of Cancer Control of the Territorial Department of Health, was organized during the past year to consider plans for getting radioactive isotopes brought to Hawaii for medical purposes.

The tumor clinics at Queen's and St. Francis Hospitals were continued during the past year, and a new tumor clinic was started at Kuakini in September, 1950, under the direction of Dr. Walter Quisenberry. Physicians have shown considerable interest in these clinics and have received much assistance from them. The average attendance at each clinic has been 30 to 35 doctors.

The color sound movie titled, "We Speak Again," was purchased by the Bureau of Cancer Control of the Territorial Health Department during the year for use by the otolaryngologist in teaching laryngectomized patients esophageal voice, and to promote better understanding in the community on the rehabilitation of treated cancer patients.

The Territorial Medical Association and the Cancer Society have continued their cooperation with the Territorial Department of Health in analyzing data covering a five year morbidity study on cancer in the Territory of Hawaii.

REPORT OF THE ADVISORY COUNCIL  
FOR THE WOMAN'S AUXILIARY

T. H. Richert, M.D., Chairman

There were no formal meetings held during the year. Upon several requests, Mrs. Halford, President of the Auxiliary, contacted me by telephone to ask my advice on matters of the Woman's Auxiliary.

Upon request of the Treasurer, the books of the Auxiliary were checked, and found to be in order.

REPORT OF THE COMMITTEE ON  
PSYCHIATRY AND NEUROLOGY

William H. Stevens, M.D., Chairman

I shall be leaving shortly for an extended period of vacation and advanced study on the mainland. Since the time for appointment of new officers in the Territorial Medical Association is almost at hand, it will probably not be necessary for me to tender a formal resignation as head of the Committee on Psychiatry and Neurology. In the interim perhaps Dr. John Lowrey could fill in until a new committee chairman is appointed.



I have summarized briefly the activities of this committee for the past year, in case it is desired to have them reported at the next annual meeting of the Society:

1. Several meetings in conjunction with a special committee to consider the application of existing legislation as it pertains to the licensing of mental institutions in the Territory, and having particular reference to recent misunderstandings between the Board of Health and South Shore and St. Francis Hospitals. The matter was thoroughly ventilated and discussed, and appropriate recommendations were made to the Medical Society, as requested.
2. Pursuant to a request from the Director of the Territorial Hospital, Kaneohe, the committee appointed Dr. Dorothy Natsui to affiliate with the Directors of Nursing as a Consultant to the Education Committee on Psychiatric Nursing.
3. Collection and dissemination of pertinent material on Psychological Factors in Atomic Warfare, in coordination with the Territorial Disaster Relief Organization, and the National Preparedness Committee of the American Psychiatric Association.
4. Representation at a joint meeting of several interested agencies in connection with preliminary planning for a proposed Institute on Mental Health to be held in Honolulu this coming fall and winter.
5. A review and compilation of proposed legislation pertaining to mental health in the Territory, and in conjunction with the Society for Neurology and Psychiatry, the introduction of several needed statutes and statutory changes before the current legislature.

### REPORT OF THE COMMITTEE ON THE REVISION OF BY-LAWS

**Samuel L. Yee, M.D., Chairman**

The President appointed a Committee on the Revision of By-Laws this year. This Committee has made no recommendations for amendments to be proposed at this session, but does recommend that study of the Constitution and By-Laws be continued.

We would suggest that a Committee on the Revision of By-Laws be a standing committee of the Territorial Medical Association.

We should also like to suggest that consideration be given to abolishing the Council entirely, and having the functions taken over by the House of Delegates. It is felt that should problems arise which heretofore required the deliberations of the Council, a meeting of the Delegates could be called instead.

It is also recommended that the House of Delegates should consist of some members of the Board of Governors of the component county societies.

It is further recommended that nominations for president-elect be circulated to the general membership at least ten days before the annual meeting.

The president-elect should be an official member of the House of Delegates, with full voting powers.

### REPORT OF THE BOARD OF MANAGEMENT MABEL L. SMYTH MEMORIAL BUILDING

**Rodney T. West, M.D.**

On January 4, 1951, the Mabel L. Smyth Memorial Building concluded ten years of activity. During this time it has served the medical and nursing professions, health and welfare organizations, and in a limited way, the general public. In these ten years, exclusive of the Medical Library, and the routine business of the organizations which it houses, 289,200 people have used the building, and the auditorium has been used 1,918 times.

We have already outgrown our facilities. A request has come through the Oahu Health Council, and on the recommendation of Dr. Ira Hiscock during his recent survey, from various health and welfare organizations, for office and workshop space in this building.

In accordance with this request, a building committee has been named, consisting of representatives of the various interested organizations and representatives of the medical and nursing professions, to study possi-

bilities of an addition. How an addition can be financed has not been determined, but we do need to expand.

The Mabel L. Smyth Memorial Building, whose total expenditures for last year were \$11,409.85, is not endowed, but is maintained by income from three sources:

1. Rental of offices, auditorium and committee room.
2. Interest from a \$10,000.00 investment.
3. Catering services in the lounge.

Our budget for 1951 is \$11,877.50. The Building has recently taken a membership in the Honolulu Chamber of Commerce, hoping to increase auditorium rentals through contacts there.

The Building is tax exempt because it is an eleemosynary institution, but we do have Social Security and Employment Security taxes.

During the past year a Steinway piano has been purchased, others having previously been here from Thayers, on loan, only. New venetian blinds have been installed in the Library and Medical Office.

Anything that can be done to stimulate rental of the auditorium or the use of the lounge for dinner meetings, receptions, teas, etc., will add to our funds. The Bishop Trust Company plans to hold a Financial Forum for Men on eight evenings in May, and we look forward to a good Pan-Pacific Surgical Conference next November. Any suggestions or constructive criticisms regarding management of the Building, will be welcomed by your two representatives, Dr. William Ito and myself.

In closing, the Board of the Mabel L. Smyth Building, enlists the support of all the doctors in furthering the use of the building for income producing meetings, receptions, etc., because it is only by means of funds collected for such, that we are able to continue to give good service and keep the building in excellent repair. Also, remember that any donations to the Building are tax exempt.

### REPORT OF THE POSTGRADUATE COMMITTEE

**V. C. Waite, M.D., Chairman**

During the past year this committee of one has investigated the potentialities of a plan for postgraduate experience which would reach all members of the various County Societies, and uppermost in our mind throughout the year has been a sincere effort to offer some degree of postgraduate education to the man in general practice. It became apparent early in the year that most prominent medical men visiting the Islands as tourists, were reluctant to offer their services unless preparations had been made prior to their arrival. Several outstanding educators did render significant contribution to our professional group while visiting here. However, I must admit in spite of our efforts, the Honolulu Society remained the greatest recipient of what was offered. This, of course, is justifiable to some extent, due to the increased number of men in this locality. However, it is still of very little help to the man in Kohala or Waimea. During the year the following postgraduate programs were offered:

1. Dr. Louis River of Loyola University School of Medicine in Chicago, spoke to the Hawaii County Medical Society on Breast Cancer.
2. Dr. Arkell M. Vaughn, Associate Clinical Professor of Surgery at the University of Illinois, spoke to the Hawaii County Medical Society on Cancer of the Stomach.
3. Dr. Arthur E. Lewis, Clinical Professor of Proctology at the University of Washington Medical School, discussed Anorectal Surgery before the Kauai County Medical Society.
4. Dr. Harold Civin and Dr. Thomas Fujiwara journeyed to Maui during the spring, and discussed Blood Dyscrasia and Laboratory Medicine with members of the Maui County Medical Society.

5. Dr. Hugh Hamilton of Kansas City, discussed the problem of blood changes during pregnancy, before the Honolulu Obstetrical and Gynecological Society.
6. Dr. William Bernhoft, Associate Clinical Professor of Surgery at the Buffalo School of Medicine, presented the problems of adenomas of the colon, on Kauai in April.
7. Dr. Corwin Hinshaw of Stanford University, presented an excellent series of lectures to all societies on the problem of chest disease in general, and tuberculous disease in particular, during the recent two-week period.

There were many other actual postgraduate experiences offered during the year, with which this committee was not concerned, but which should be mentioned. The Territorial Association of Plantation Physicians conducted its usual well organized and instructive session on Kauai. Of course, the various specialty groups here in Honolulu have had frequent mainland educators, and these meetings have been open to all members of the Society. It seems unnecessary to mention the postgraduate program, which is supported by the Honolulu Society each spring, and this fall the Pan-Pacific Surgical Association meeting will be held during the early part of November.

All of these somewhat diversified programs are excellent sources of information, and offer some stimulus in helping us keep up with the changing times in medicine and in rendering more and better medical care to our patients. Although the past year has brought about some improvement in these opportunities, I have not been satisfied with the progress, and in my opinion the Society is capable of doing a better and more efficient job, and to this end I present the following recommendations:

Our great need is to reach the general practitioner—the man who practices in a community or on a plantation by himself, who has little or no professional relief, and who cannot take the necessary time to leave his office and take postgraduate work on the mainland. He is the man who must rely on the varied medical periodicals along with exchanging ideas with his colleagues, as the only sources of new information and progress in medicine in general. However, most of the journals, as you know, are filled with papers written by innumerable young men who are eager to get their names in print. We all know that many of these papers are worthless to the general practitioner, and the latter does not have the time to cull over the vast medical literature to pick out only the really significant articles that will be useful to him in his diversified practice. I believe it to be a genuine function of the Territorial Society to provide help in this direction, and that greater effort must be directed for this purpose in the future.

A good postgraduate education program should be so organized in advance for the coming year, that recipients may make arrangements to leave their practices, if possible, for the specified purpose. Ideally, such a plan should offer refresher courses in the form of lectures, clinics or seminars which would encompass the various phases of medical practice, with the prime purpose of keeping everyone abreast of changing methods of diagnosis and treatment.

For most mainland state societies, the bulk of the responsibility for the postgraduate education program is shouldered by the medical schools. All except a few states have at least one medical school, and many are fortunate enough to have several. Such a situation simplifies the program considerably. In Hawaii we are not so fortunate, and must continue to depend somewhat on our visitors who may be willing to offer their services. However, this will almost invariably result in a program which lacks variety and gross coverage. In my opinion this Society should utilize to a greater extent, the capabilities and potentialities of its own professional group for the dispersion of medical knowledge. I would suggest, therefore, that this committee be increased in number and propriety for the purpose of organizing a well constituted postgraduate education program, in which refresher courses, clinics, lectures and seminars could be offered at intervals on all of the Islands, to be primarily conducted by qualified men in our own Territorial organization.

I am confident that there are many individuals in our own Society fully competent to render this service to their colleagues, and I am optimistic enough to believe that they will be willing to serve in such capacity. A program so established should exist on a basic standard, and could be appropriately supplemented by whatever our visitors may be willing to offer. I believe such an essential need has been neglected within our Society

too long, and that an appropriately selected committee should begin to study in organization of such a plan without delay.

## REPORT OF THE LEGISLATIVE COMMITTEE

Harry L. Arnold, Jr., M.D., Chairman

Your Legislative Committee, consisting of Dr. Henry Gotshalk, Dr. Richard K. C. Lee and me, met almost every week during the 1951 legislative session, sitting jointly with the Legislative Committee of the Honolulu County Medical Society. We studied approximately sixty pieces of medical or related legislation. Bills relating to special problems were referred to individual physicians for their opinion, in order to guide our thinking on them. Bills relating to neighbor islands were referred to the County Medical Society concerned, for their opinion. Each bill was brought up for open discussion in the committee meetings, and a decision was made either to support or to oppose, or to take no action. Two bills were referred to the Board of Governors of the Honolulu County Medical Society, which reversed their own committee's action on one of them. In no instance did your committee feel it necessary or desirable to take a different position from that of the Honolulu County Medical Society's committee.

I have represented the Committee at six hearings held by the Health Committee of the House of Representatives, four hearings held by the Health Committee of the Senate, and three hearings held by the Finance Committee of the House of Representatives, as well as brief hearings before two other committees of the House. The respective chairmen of these committees, Representative Manuel Paschoal, Senator Thelma Akana Harrison and Representative Thomas Sakakihara, have been courteous, cooperative and receptive to our views on all of these occasions, as have all of the members of the committees.

Your committee wishes to express its gratitude to the members of the Legislative Committee of the Honolulu County Medical Society, Drs. Richard Chun, Clarence Fronk, John Devereux, Homer Izumi, Y. C. Yang, Raymond Kong, Douglas Bell and B. Allen Richardson, for their faithful attendance at the joint committee meetings and for their time spent assisting the Chairman, or substituting for him, at committee hearings.

## REPORT OF THE HAWAII MEDICAL JOURNAL

Harry L. Arnold, Jr., M.D., Editor

The relatively economic ratio of letterpress to advertising space of 1.2 to 1, achieved a year ago, has been fairly well maintained in the last six issues of the JOURNAL; the ratio has actually been 1.3 to 1. Each issue of the past six has contained on the average, 33 pages of advertisements and 43 pages of text matter. The Inter-Island Nurses' Bulletin has been allowed an average of eight pages per issue. A total of 91 book reviews have been published during this fiscal year, and the review copies donated to the County Medical Library.

The net income of the JOURNAL from advertising was \$7,454.32, and from subscriptions and sales, \$2,446.50, a total of \$9,900.00. To this may be added \$449.50 worth of journals received in exchange, and \$711.00 worth of books received for review. From this total



income of \$11,060.50 must be subtracted \$9,099.38 in printing and (in part) mailing costs, and at least a token \$1,200.00 for the salary of the Managing Editor, Mrs. Bennett. It is so difficult to fairly assess the proportion of the Association's costs attributable to the operation of the JOURNAL, that about all one can do is to guess that it is approximately carrying itself financially as long as the editorial staff doesn't have to be paid.

With the final number of Volume 9, we began to publish the picture of each author of original papers, on the first pages of their respective articles, and several favorable comments have been received on this practice. The cost of this is very moderate, and is further reduced by the value, whatever it may prove to be, of having a collection of cuts of each author so favored.

In the November-December issue of last year we inaugurated a new feature, the President's Page, carrying a brief message from the President of the Territorial Medical Association, Dr. Rogers Lee Hill, with his picture and over his signature.

The Lilly advertisement on the front cover has been continued, and the advertising schedules have been maintained and even increased slightly, with an average of two more pages of advertising in each of the last six issues than in the preceding year.

Your Editorial Board feels that the JOURNAL is a reasonably satisfactory publication from the medical, the typographical, the aesthetic and the financial points of view, and recommends that you authorize its continued publication during the coming fiscal year, on the same basis as heretofore.

## REPORT OF THE PUBLIC SERVICE COMMITTEE

Richard C. Durant, M.D., Chairman

During the past year the Public Service Committee has limited the scope of its activities to include only such projects as would have a direct bearing and an immediate effect on either the members of the Territorial Medical Association, the public, or both. Arrangements were made for island-wide broadcasts of the inaugural address of the incoming President of the American Medical Association, Elmer Henderson, and the costs of these broadcasts were defrayed out of Public Service Committee funds.

The Committee contributed to the success of the National Education Campaign of the American Medical Association by expediting the circulation of appropriate literature and aiding newspapers in their efforts to sell "tie-in" advertising along the lines suggested by the National Committee. The Japanese and Honolulu Chambers of Commerce generously addressed over two thousand envelopes for us, and mailed campaign literature to their respective members. One minute spot announcements were made over many local stations to further the campaign. Its success in Hawaii was later attested by Mr. Whitaker of Whitaker and Baxter, at the National Campaign Committee meeting in Cleveland in December.

This meeting was held in conjunction with the Third Annual Public Relations Conference, and was attended by three members of the Public Service Committee. Reports on the conference were made in person by these three members to the Kauai, Maui, Hawaii and Hono-

lulu County Medical Societies, and this service was warmly received by each of the county societies.

Financial savings were accomplished during the year by cancellation of subscriptions to certain magazines and weekly news letters whose editorial policies are now principally political, or whose news stories have no particular bearing on affairs medical.

Certain interested members of the Honolulu County Medical Society voluntarily contributed to the cost of a medical public opinion poll which was completed in January of this year. Knowing that this survey was being made, and feeling that the data to be obtained was essential to the establishment of a sound Territorial public relations program, the present committee has deferred to date any elaborate planning. Now that the results of the public opinion survey are available, this conscious delay in formal planning has proven to be wise, for the survey reflects at present a very favorable public opinion climate for medicine locally. There is, naturally, considerable room for further improvement of this climate in the immediate years ahead, but the expenditure of large sums of money to inundate the public with medical information, or to influence their views on such issues as socialized medicine, would appear to be unnecessary, as most aspects of medical practice which were viewed unfavorably by the public, are practices which perforce need correction or amelioration by ourselves—the members of the medical profession.

Expenditures by the committee during the past fiscal year amounted to \$739.25. An audited financial statement appears at the end of this report.

In closing, the committee submits the following recommendations:

1. During the past year only the Executive Secretary has been authorized to sign checks on the Public Service Committee fund. Since the Executive Secretary is about to leave the Territory for six months, it is recommended that checks drawn on the fund be signed by the Treasurer of the Territorial Medical Society after approval of the expenditure by the Chairman of the Committee.
2. A friendly press and radio is essential to sound public relations. It is recommended, therefore, that an annual banquet or dinner be held by the Public Service Committee for representatives of all radio stations and newspapers locally, and that provision be made for honest discussion of any medical policy or topic of current public interest.
3. At the close of this fiscal year there remains in the Public Service Fund \$1,693.19. This should be more than adequate to finance a public relations program for the ensuing year. Provision should be made, however, to insure future funds for reasonable expenditures, and the expense of a public relations program should be a part of the budget of the Hawaii Territorial Medical Association.

## TERRITORIAL MEDICAL PUBLIC SERVICE COMMITTEE

February 28, 1951

Bank of Hawaii.....	\$1,693.19
Furniture & Fixtures.....	344.50
Audit .....	20.00
Literature & Research.....	310.51
Miscellaneous Expense .....	6.25
Postage .....	92.64
Radio .....	309.50
Salaries .....	19.50
Supplies .....	52.50
Taxes .....	1.05
Telephone & Telegraph.....	29.56
Travel .....	80.90
Woman's Auxiliary .....	46.05

\$3,006.15

## REPORT OF PREPAREDNESS COMMITTEE

Robert B. Faus, M.D., Chairman

Six meetings of the Preparedness Committee were held throughout the year. This Committee consisted of

Dr. Faus, Chairman, Drs. Arnold, Sr., Strode, Hill, Stewart, Orenstein, Burden and Wade. The alternates, Drs. Kawasaki, Gotshalk, Gaspar, Fronk and F. J. Pinkerton of the Honolulu County Medical Society, attended meetings on request, and in the absence of any member of the committee, the alternates were called in the proper order. It has been found unnecessary to have the doctors from the other Islands attend these meetings, but they were consulted by mail on any questions relating to their own Island.

Much has been done on the part of the Preparedness Committee to coordinate plans for civil defense, the assignment of doctors to aid stations, and to the hospitals and Blood Bank, and the consideration of deferment requests for physicians in hospitals to Selective Service and the armed services.

A remarkable piece of work was done by Dr. Hill and Dr. Cherry in reviewing all recent literature relative to the treatment of burns, and compiling a monograph that outlines the procedure whereby a large number of burns can be taken care of with the least amount of professional help. This monograph has received favorable comments nationally from members of the Civil Defense Section, National Security Resources Board, National Emergency Medical Service, American Medical Association, and many other rating physicians and surgeons throughout the United States. Dr. Hill and Dr. Cherry are certainly to be commended for a fine piece of work.

Relative to personnel and procurement and assignment of physicians according to priorities established by selective service, committees have been appointed representing each of the Societies whose recommendations are considered by the Advisory Committee to Selective Service, consisting of Drs. Faus, Wilbar and Dawe. Thus far, all requests for deferments have been granted, and nine physicians have applied for and received commissions in the medical service, United States Army. Two physicians were called to active duty.

Educational programs have been sponsored for the physicians on all the Islands, relative to radiologic effects of atomic bursts. Drs. Domzalski, Wilbar, Wipperman and Haywood all received special training on the Mainland. Over 200 physicians attended the special training course in atomic explosions, given under the auspices of the Board of Health on Oahu and Maui, and received certificates of attendance. Your Chairman has visited each of the other Islands, and discussed preparedness plans with them.

It is gratifying, indeed, to find that Hawaii leads the nation in its planning and training phases which are important items of civil defense.

## RECOMMENDATIONS OF THE ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL & CHILD HEALTH

H. M. Patterson, M.D., Chairman

The 1951 Annual Meeting was held in the Stella Lowrey Room of the Mabel Smyth Building. The following attended:

Dr. H. M. Patterson <i>Chairman</i>	Dr. Kemp	Dr. L. T. Chun
Dr. Phillips	Dr. Kuhns	Dr. Nishijima
Dr. Bernstein	Dr. Tompkins	Dr. Reppun
Dr. Bowles	Dr. Spencer	Dr. Wilkinson
Dr. Choy	Dr. Tom	Dr. Hetter
Dr. Seymour	Dr. Natsui	Dr. Lee
	Dr. Lathrop	Dr. Stitt
	Dr. Connor	

The recommendations of the Committee are as follows:

1. That the Bureau of Maternal & Child Health circularize all physicians in Hawaii, recommending that all obstetrical patients should have blood grouping and Rh typing done when they first seek prenatal care.
2. That this be re-emphasized as a must: That all hospitals make available direct personal supervision of obstetrical patients for at least one hour after delivery.
3. That the Bureau of Maternal and Child Health ask the attorney general for an opinion as to the legality of physicians and hospitals making available to the sub-committee on fetal and neonatal mortality all hospital records on any maternal, fetal or neonatal death.
4. We recommend to the Bureau of Maternal and Child Health and Crippled Children, Department of Health, that they provide as needed, pediatric and psychiatric consultation services to physicians conducting prenatal conferences.
5. That a summary of the commonly accepted procedures in the management of the delivery of a premature infant, with special reference to the omissions of the use of sedative drugs to the mother, be circulated to all hospital staffs and physicians of the Territory.
6. That the Bureau of Maternal and Child Health furnish pediatric consultations in emergency situations, as are now being furnished in such obstetrical emergencies.
7. After a rather lengthy discussion of the EMIC program of the past and possibly for the future, the committee recommends that the last questionnaire sent to the Hawaii Territorial Medical Association from the American Medical Association, be answered Na in both categories; that is, that there is no need and no demand here at present for such a program. There has been one inquiry to the Bureau of Maternal and Child Health from the Department of Public Welfare, and one inquiry to the County Health Officer on Kauai, and one to the County Health Officer on Hawaii. The committee feels that any such program should be thoroughly studied and that the Territorial Medical Association should follow the lead of the American Medical Association if such a program is developed.

## RECOMMENDATIONS OF THE ADVISORY COMMITTEE TO THE BUREAU OF CRIPPLED CHILDREN

T. Alan Casey, M.D., Chairman

The 1951 Annual Meeting was held in the Stella Lowrey Room of the Mabel Smyth Building. The following attended:

Dr. Casey, <i>Chairman</i>	Dr. Crawford	Dr. Lathrop
Dr. Dodge	Dr. Holmes	Dr. Pang
Dr. Lowrey	Dr. Bernstein	Dr. Larsen
Dr. White	Dr. Seymour	Dr. Wilkinson
Dr. Kemp	Dr. Goodhue	Dr. Tompkins
Dr. Uyeno	Dr. Kuhns	Dr. Reppun
	Dr. Lee	

The recommendations of the Committee are as follows:

1. That this Committee should meet quarterly instead of annually, as in the past. This is felt to be important. The Committee functioning in this way, will obtain more reliable and complete information and will be able, therefore, to more wisely advise, and be able to follow-up an individual problem.
2. That this Committee be empowered by the House of Delegates, Hawaii Territorial Medical Association, to act in an advisory capacity when such is requested by various agencies and committees, etc. And that in particular this Committee, therefore, be the Medical Advisory Committee to the Implementation Committee for Act 29. (This Act has created a means of furthering educational opportunities for exceptional children.)
3. That a sub-committee composed of Drs. John Halmes, Wayne Wang, L. Q. Pang, and a representative for each of the outside islands, study the problem of eye care by the Bureau of Crippled Children and related problems, and report back to this Committee at its interim meetings.
4. That the aid of the Hawaii Territorial Dental Association through member, Dr. Uyeno, be enlisted during the year in obtaining general information upon the orthodontic and prosthodontic problem, and possible methods for its accomplishment.
5. That Drs. H. E. Crawford and J. W. White appeal to proper members of the Territorial Legislature to work for the increase of Bureau of Crippled Children allotment from \$75,000 to \$125,000. And that other members of the HTMA do the same.
6. That since the Advisory Committee to the National Society for Crippled Children and Adults is presently formulating a plan of medical directorship, that this Committee undertake a statement of advice on this problem unless such advice is further sought.



## *Now Available---*

*To Doctors insured under the Disability Plan of the Medical Society.*

## **HOSPITAL COVERAGE FOR DEPENDENTS**

1. A Family Plan under which you may exclude coverage for yourself.
2. A Plan designed to Supplement Existing coverage. Use it to pay the additional expense incurred for:
  - Private hospital room
  - Hospital Extras not covered by existing insurance
  - Longer periods of hospitalization
  - Nursing Care at Home
  - Excess Maternity Costs
3. Low Cost. For approximately 10c a day a Doctor may insure his wife and two dependent children for the benefits described herein.

## **THE QUALITY HOSPITAL POLICY--**

**Pays \$6.00 PER DAY UP TO 100 DAYS**

The full daily benefit for hospital room and board, for as long as 100 days for each accident or sickness.

**Pays FOR MISCELLANEOUS HOSPITAL EXPENSES**

Up to 10 times the daily benefit for X-ray examinations, laboratory tests, oxygen tent, dressings, drugs, operating room and anaesthetics.

**Pays \$5.00 PER DAY FOR NURSE SERVICE**

Full daily benefit for a registered nurse in the house for as long as 100 days, while totally disabled and house confined as the result of an accident or sickness.

**Pays UP TO \$25.00 FOR EMERGENCY TREATMENT**

Performed in a hospital within 12 hours after an accident, even though not a bed patient. This payment is made in lieu of any other benefits.

**Pays FOR MATERNITY UNDER FAMILY GROUP PLAN**

Up to 10 times the daily benefit for maternity, after your wife has been insured for 10 months under the Dependents Rider. Covers either *IN HOSPITAL* or *AT HOME*.

**The limits of coverage shown are suggested only for the purpose of supplementing existing insurance. Higher limits and other coverages are available where primary insurance is desired.**

• • • *Underwritten by* • • •

**The United States Life Insurance Company**

*For Additional Information Call or See*

**Mitchell Hutchinson, CLU**

**BRAINARD AND BLACK, LTD.**

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

---

## BULLETIN COMMITTEE

ANGELA M. CARLUCCI, *Editor*, Leahi Hospital, Honolulu  
LAURA DRAPER, *Nursing Information Committee*, Board of Health, Honolulu  
LEAH BIGELOW, *Nursing Information Committee*, St. Francis Hospital, Honolulu  
MABELCLAIRE NORMAN, *Executive Secretary*, Honolulu  
ALISON MCBRIDE, *Territorial Association Secretary*, Honolulu

### *Secretaries*

BESS HAMMER, Hawaii  
VIRGINIA RAUTENBERG, Honolulu  
PAULINE JOHNSON, Kauai  
LAURA WONG, Maui

### *Publicity Chairmen*

GRACE LUSBY, Hawaii  
HELEN GAGE, Kauai  
MICHIE KAMITAKI, Maui

---

## ISOLATION TECHNICS IN TUBERCULOSIS NURSING

ANNE C. CAMARA, R.N.\*

The essentials of medical asepsis as applied to tuberculosis nursing are thus defined by Dr. William H. Oatway, Jr., of Barlow Sanatorium in Los Angeles: "aseptic technic is a routine for protecting the contacts of tuberculous patients. It consists of a number of logical methods to prevent the spread of infection which are applied to the patient, to his contacts, and to his environment. It involves facilities for isolation, placement of the patient, and the care of the patient."

We are all aware of the fact that for many, many years, constant study, constant evaluation and constant research have been spent in perfecting technics by outstanding men and women in the tuberculosis and allied fields, but up to this day, complete, conclusive preventive measures for tuberculosis protection have not yet been discovered. There are still many gaps in what is specifically known about the tubercle bacillus, its mode of transmission, and the most effective agents for its control, but one thing is quite certain and that is: "careful and complete use of what we do know will prevent heavy exposure to tuberculosis germs and will minimize hazards, thereby reducing the risks or dangers of infection." Such precautionary measures may slow down procedures and may cost more, but those who are concerned with the control of tuberculosis know that the values which concern the well-being of individuals and of the community are those which decide our final aims. We must not overlook this important step in protecting those values.

Successful administration of established protective practices depends primarily upon a sound educative process of both the nurse and the tuberculous patient. For the nurse, there must be thorough understanding of tuberculosis as a disease and complete awareness of the full meaning of cleanliness, asepsis, contamination, disinfection, sterilization, etc. She must be adequately instructed in methods of handling highly infectious material such as sputum, blood and other body discharges, particularly chest drainage. In addition, there must be complete understanding of methods of avoiding contamination of self, others and surroundings, as well as methods of decontamination of self, equipment and surroundings.

For the patient, effective bedside teaching by the nurse is instrumental in promoting safety, once the cooperation and confidence of the patient is established. Such an educative process is highly effective in abolishing fears, ignorance, insecurity and false ideas.

There is still great need for research and scientific study on the whole problem of isolation technics in the tuberculosis ward. Considerable disagreement still prevails over the degree of aseptic technic to be used. Consequently, preventive measures differ throughout the country. Innumerable scientific research projects are constantly being studied and analyzed. Outstanding among these are:

1. The value of the BCG vaccine as an immunizing agent against tuberculosis.
2. The efficiency of such agents as caps, gowns, masks and handwashing technics.
3. The value of antiseptics, disinfectants in destroying the tubercle bacillus such as alcohol, cresol, etc.

\* Instructor, Leahi Hospital, Honolulu, T. H.



4. The problem of air-borne infection and dust and the value of oils, ultraviolet light and vacuum cleaners.
5. The question of tuberculin testing and the employment of negative reactors in tuberculosis hospitals.
6. The value of constitutional resistance of hospital personnel.

These are some of the many problems which we hope may be completely answered from time to time.

### LOCAL DIAGNOSTIC FACILITIES IN TUBERCULOSIS

ROBERT H. MARKS, M.D.\*

There is nothing deeply mysterious regarding the cause of tuberculosis as a health problem in any community. Boiled down to its essentials, there are two factors which conspire to cause tuberculosis to exist to an undesirable extent in any locality. These factors are first, type of environment, and second, the number of infectious cases of tuberculosis in the community.

The *Mycobacterium tuberculosis* belongs to the class of living organisms that is half way between bacteria and the higher plants. As any plant, it needs the proper soil in which to grow and thrive. Wherever we find miserable housing, crowding, inadequate diet, poor sanitation, ignorance, unusual financial or emotional strains or stress—there we are more apt to find tuberculosis. Medical efforts can do little to ameliorate these conditions. They require social reform, health education, attention to sanitation and slum clearance. It is true that the Health Department can and does exert efforts toward health education and improvement in sanitation, and it is also true that the medical profession and the Health Department can help to alleviate individual emotional stresses, but definitely only the community can supply the facilities to prevent the spread of tuberculosis from one case to another.

Each case of tuberculosis is derived from another, and each case can potentially infect many others. It follows that if we were able to locate and diagnose every case that exists, and properly supervise or adequately treat all of these cases, we could soon eliminate the disease. We do not mean that we have to locate only the infectious cases. One of the most exasperating characteristics of tuberculosis is its tendency to relapse. Anyone who has x-ray evidence of a significant pulmonary involvement, even if it is considered inactive or arrested, should be constantly and carefully supervised for a long time. Among the 5,000 cases of tuberculosis on the Territorial case register are about 3,500 arrested cases, of which approximately

10 per cent recrudescence each year, many of them having been inactive for ten or more years.

How does the community attack the problem of the spread of infection with tuberculosis? The work of tuberculosis control can be divided into four main functions:

1. Case Register
2. Casefinding
3. Diagnosis and follow-up facilities
4. Treatment and isolation facilities

I need not emphasize, I hope, that this work is not the responsibility of the health department alone, or of the sanatoria, or of the tuberculosis associations, but of everyone, including the private physicians.

In 1909 the legislature made it a law that all cases of tuberculosis be reported to the health department. This register is an essential tool of tuberculosis control. By means of this register we are able to make the necessary epidemiological investigations to determine the elementary but essential knowledge as to (1) where did this patient get his tuberculosis? and (2) to whom might he have given it?

As an example of the need for this register and the reporting of tuberculosis, let me cite a recent situation that embarrassed us no end. A young Hawaiian mother was found with active progressive tuberculosis a year or two ago. Her children were apparently properly protected because two months after her death six months ago they were still tuberculin negative—no evidence of infection. When the mother was first diagnosed, it was found on routine contact investigation that the likely source of her tuberculosis was her father who was found to have chronic disease with positive sputum. He refused hospitalization and since he lived alone with his elderly wife, it was felt that we would not need to press hospitalization. There is where we made a mistake, because last week the two grandchildren were routinely examined and found to have active disease with positive tuberculin test. Their father, not happy with the foster home into which they were put after their mother's death, sent them to his father-in-law, who took care of them—so well that they are now in Leahi. This failure of ours to properly use what we know is perhaps a better example of the necessity for strict control measures, and also a better example of the importance of the awareness of the infectious nature of tuberculosis, than some more successful and gratifying example.

I must say that the consciousness of the need for reporting cases on the part of the private physician is gratifying in this community, but too many times we hear obliquely, by death certificate, by admission to the hospital, or other means, of

\* Chief, Bureau of Tuberculosis, Territorial Department of Health.

an unreported case of tuberculosis. Obviously the physician had forgotten or neglected to report it. These delays in reporting cause a delay in searching the contacts and an unnecessary spread of infection on the part of the unrecognized source case. It should be also obvious that pulmonary tuberculosis is not the only type of tuberculosis that should be reported—extra-pulmonary tuberculosis, such as renal or glandular tuberculosis, and pleural effusions with no other etiology, even though they are not usually considered infectious, should also be reported so that adequate search for the source can be made. In this connection the office nurse can do much to help her doctor employer by bringing it to his attention that Mrs. X should be reported and by even filling out the report card for him to approve and sign.

We also find that it is not enough to merely say to the patient who has tuberculosis that he should see that his family and friends are x-rayed or tuberculin tested. We find that it is necessary to obtain the names of all the possible contacts as soon as possible, and if they do not show up for examination, to seek them out by letter, phone, or visit by the public health nurse.

The same applies to the case of tuberculosis that the private physician is carrying as a private case. If he does not show up for his examination or treatment, the health department stands ready to assist in getting him back to the doctor's office for that examination or treatment.

The next necessary procedure in tuberculosis control is vigorous casefinding—searching for the unrecognized undiagnosed case.

Examining the contacts of the newly diagnosed case is one important method already discussed.

Examining for tuberculosis by tuberculin test or x-ray those people who present themselves to the doctor's office or clinic with the common symptoms attributed to tuberculosis is another.

X-raying or tuberculin testing the apparently healthy person is still another.

By 1940 an x-ray machine had been perfected whereby the image cast on a fluoroscopic screen could be photographed. The camera used was the familiar miniature or candid camera taking pictures on small film in rolls. Hundreds of people a day can be x-rayed quickly and cheaply by these x-ray machines, making it possible and economically feasible to x-ray every person in a community if their cooperation could be obtained.

The Territory operates three such mobile units, one always on Hawaii, the other two used on Oahu and the two counties of Maui and Kauai. Periodic examinations of whole communities, of large and small business and industrial firms, of high school

and college students and faculties are made. Yearly x-rays are legally required on foodhandlers, teachers, barbers, masseurs and tattooers. Over one half of the cases becoming known to the health department are discovered by these surveys. In addition to these mobile units in the chest clinic at Lanakila Health Center there is a small film survey unit open to the public every week day (except Saturdays). Anyone can obtain a survey type x-ray there, and the private physician is invited to send any of his patients there for a screening film. The Health Department also has a 4x5 inch x-ray unit in The Queen's Hospital that is supposed to be x-raying all admissions. Actually and unfortunately only about 10 per cent of the admissions are x-rayed. About two suspicious cases per 100 x-rays are discovered by this unit. How many cases are unwittingly causing an unknown and unrecognized hazard to the hospital employees and nurses from the 90 per cent who are not x-rayed when they are admitted? If a hospital wishes to give sound protection to its employees and nurses, it should make sure by chest x-ray on admission or as soon as feasible after admission that every patient in the hospital who may have infectious tuberculosis is known so that proper precautions can be taken. It most definitely should be made a routine procedure in every hospital.

If the prevalence of tuberculosis in people entering hospitals is high, then it must also be true that an alarmingly high number of cases of unrecognized tuberculosis pass through the average physician's office. Some doctors now make a practice of routinely fluoroscoping or x-raying many of their patients—particularly the expectant mother and the medical cases. The percentage of the general population, especially in the younger age group, who are infected with tubercle bacilli as shown by a positive tuberculin test is becoming smaller and smaller. It would be entirely feasible for every general practitioner to routinely tuberculin test his patients and recommend an x-ray if the test is positive. In the pre-school child if a positive tuberculin test is found, it becomes imperative to recommend the examination of the immediate family to find out where that child acquired his infection.

The third required tuberculosis control measures—facilities for the diagnosis and follow-up examinations of persons with tuberculosis or of persons who are suspected to have tuberculosis because of symptoms or abnormal findings on x-ray—must be readily available. And so that finances will be no barrier, tax-supported facilities for diagnosis must be provided, in addition to the private physician and general hospital.



When a lesion or abnormal shadow is discovered on an x-ray, it must be determined, first, is it tuberculosis or some other important condition? and second, if tuberculosis, is it active and infectious, or is it inactive and not infectious? This is not easy to determine. It requires first a tuberculin test. If that is negative, it is not tuberculosis. If positive, careful search of bronchial secretion for the tubercle bacilli is necessary. We have found that the examination of a stained sputum smear is not enough; cultures of the sputum must be run. In many instances the person has no cough or sputum and in these cases culture of specimens of fasting gastric contents or of tracheal lavage specimens must be made—not one, but several. It has been found that if these are negative, serial periodic x-ray examinations must be made. When a suspected tuberculosis lesion is discovered by us in the surveys, therefore, we refer that individual to his private physician or to the clinic at Lanakila Health Center for these examinations. The private physician, if he wishes, may refer these patients for these examinations to the chest clinic at Lanakila Health Center—with no charge to the patient—the x-ray and diagnostic facilities of the chest clinic are free.

In this brief discussion I have tried to show: (1) that the discovery and adequate supervision of every tuberculosis case in the community is not only possible but necessary to control tuberculosis; (2) that facilities for this discovery and supervision are available; and (3) that the general hospital and the private physician share with the health department the responsibility of eventually eliminating tuberculosis.

#### A FOLLOW-UP STUDY OF A MASS X-RAY SURVEY

ADELE P. SCHLOSSER

About two years ago, at the request of the Territorial Tuberculosis Association, two representatives of the National Tuberculosis Association made a study of the tuberculosis control program in the territory and found a well-planned, progressive program here. In order to make the program even better, however, their main recommendation was that certain aspects of the control program be studied to see how and where they might be improved. Since case finding was the first area listed for study, the Advisory Committee appointed to direct the work suggested that a follow-up study of the 1947 survey be undertaken. It was believed that complete data on what has happened in the three year interval to the patients who were discovered through the survey

might give some indication of the gaps and values of this method of case finding and from such a study it might be possible to make recommendations for future programs.

In this study we have included only new cases of tuberculosis—i.e., people who were not on the case register at the time of the study. Omitting those who did not return for 14x17 follow-up or who left the territory before follow-up was complete, we abstracted information on 858 individuals who were considered as having probable or suspicious tuberculosis on the large film. The group includes 510 men and 348 women.

The median age of this group was 46.1 years, with the men quite a bit older than the women—their median age was 49.8 years as compared with 41.3 years for the women. These age data are interesting and significant because we know from a study completed by Dr. Brodsky and Dr. Marks immediately after the survey that the majority of people who participated in the survey were below 45 years of age. (The median age of the total group x-rayed was 38.1 years.) Our data show, however, that although persons 45 years of age and over constituted only 23 per cent of the total of 92,207 x-rayed, 45 per cent of the active cases found were in this age group. We have always talked about tuberculosis as a disease of young adults and it is still an important problem in this age group. The increasingly high incidence of active disease among older persons, especially men, makes it necessary, however, to revise our ideas somewhat and to devote greater effort to finding and treating tuberculosis in this group—to give these people the opportunity to recover and to remove a source of infection from the community. As Dr. Medlar, of the N. Y. State Health Department has said, "Too much emphasis cannot be given to the problem of tuberculosis in males beyond middle age, for it is my belief that unrecognized spreaders of tubercle bacilli in this segment of the population are the greatest source of new cases."

The data on race are of only limited usefulness, since population breakdown by race was not available for the city of Honolulu at the time of the study. According to this study, the highest proportion of active tuberculosis was found among Korean and Hawaiian patients. These data are open to some question because of the small numbers in these two groups and because the city wide survey does not give a true picture of the racial distribution of the population. On the whole, however, the findings with regard to racial distribution were similar to those already known to the Tuberculosis Bureau from previous morbidity

\* Research Analyst, Tuberculosis and Health Association.

and mortality statistics. Even though the situation with regard to incidence of tuberculosis by race offers nothing new or different, it might be well to consider more intensive education with the groups who have the greatest tendency to develop the disease.

In the three year period between completion of the survey and this study, 238 patients have been diagnosed as having active disease. The incidence of active disease among the 92,207 persons x-rayed is 0.26 per cent. Although well over half of the total number who had active disease were diagnosed almost immediately, it required a year or more to establish a diagnosis of active tuberculosis for over a third of the 238 patients who needed treatment and careful medical supervision. Tuberculosis is a difficult disease to diagnose unequivocally, and the importance of protracted follow-up until all active cases are found is brought out clearly in this and other studies of mass surveys. The public health nurse has a great responsibility in this follow-up procedure to interpret to patients why they must continue to have x-rays, why it is necessary to submit sputum specimens, why the family members should be x-rayed, so that patients will be willing to assist the physician in completing the diagnosis.

Data on stage of disease of patients with active disease show that 30 per cent had minimal tuberculosis, 58 per cent had moderately advanced disease, and 12 per cent were far advanced. These figures indicate that patients being found through surveys are admitted to sanatoria in an earlier stage than those discovered through other sources. Of the patients admitted to Leahi Hospital from all sources in 1947-48, 15 per cent had minimal tuberculosis, 50 per cent were moderately advanced and 35 per cent had far advanced disease. Examination of apparently healthy populations through mass surveys makes it possible to find tuberculosis when it is in an early stage and most amenable to cure.

There is quite a striking sex difference with regard to the incidence of active disease in men and women. A larger percentage of the men x-rayed had active disease, and more men than women had moderately and far advanced disease.

Almost 70 per cent of the 238 patients with active disease received treatment in tuberculosis hospitals; 14 per cent were cared for at home; and about 16 per cent were supervised by chest clinics. The percentage accepting hospital care, which is recognized as the most effective type of care, is commendable. It would be even better, however, if all patients who needed sanatorium treatment could have been persuaded to accept it.

The speed with which patients were admitted to the sanatorium indicates the excellent planning and preparation which went into the survey. Sixty-three per cent of the 165 patients who were hospitalized were admitted within one month after a diagnosis was made, and almost 81 per cent of this total were admitted for care within three months after their diagnosis was made. Fifty patients are still in the sanatorium three years after the survey was completed. Some of this group were admitted recently; some have been admitted for the second time, and some have spent the entire period in the sanatorium in an attempt to regain and maintain health. We have heard this many times and in many different ways, but these observations bring out strongly the inescapable fact that tuberculosis is a chronic, long-term disease with a tendency to reactivate. Finding tuberculous patients through surveys or any other means is only a small part of a case-finding program. We must provide all the facilities and services which will help patients to accept and complete long-term treatment.

After a three year period, about three-quarters of the 858 patients included in the study are classed as "inactive"; 11.5 per cent still have active disease; 34 or slightly over 4.4 per cent are dead. Of the 238 patients who had or have active disease, more than half are now considered inactive, over one-third have an active classification, and 10 per cent are dead. Of this last group of 24 people, 18 died of tuberculosis.

Although a mass survey is a relatively short, intensive program, it continues quietly long after the excitement of x-rays, publicity, etc., are over. At the present time, almost half of the total of 858 are still being supervised by clinics; 13 per cent are under the care of private physicians; and 5.8 per cent are still in the sanatorium. The relatively small percentage of the total (13 per cent) who have remained unlocated or who have refused supervision is concrete evidence of the excellent follow-up which is such an important part of the entire survey process. The large number of patients with some previous examination with tuberculosis, who have been brought to the attention of the Board of Health and who have continued under supervision is further evidence of the importance of this type of case-finding. Those briefly are the chief findings of the study.

In reviewing the results of this city-wide survey, we can see many real values which have derived from it. A substantial number of individuals with active tuberculosis have been found and, in most instances, have been treated. Discovery of these active cases has the double advantage of



treatment of the sick person and protection of other members of family and community. An even larger group of individuals who have at some time been infected with tuberculosis has been brought under medical supervision and, in the majority of cases, these persons with inactive disease are still receiving the kind of supervision which is necessary to prevent any breakdown. Patients found through surveys are found in an earlier stage of disease than are those discovered through other sources. Mass surveys, at the present time, constitute the major source of our new cases of tuberculosis.

Study of the results of this survey, however, point up areas which need more intensive, concentrated effort. We must try even harder to reach older persons—especially men—as a source of active tuberculosis. We must continue to direct our attention to specific high incidence groups and areas in the community so that we can offer regular chest x-rays to as many people as possible. We must also keep in mind the important by-products of chest x-ray surveys. This type of case finding can be of tremendous assistance in finding other kinds of chest pathology—especially cancer and heart disease. In order to make the fullest use of this mass screening method, there must be close cooperation and program planning by representatives of all the voluntary and official agencies concerned with these health problems.

One approach to reach some of the older population who are not responding to mass surveys might be through an expansion of general hospitals admission chest x-ray programs. This type of program has been found to be effective as a source of new cases and is believed to be well worth the expense where it has been tried. Dr. Siegal of the New York State Dept. of Health has said, "It is among the older people, especially the males, that most tuberculosis and cancer of the lungs are found. In the hospital program it is possible to x-ray all of the older patients who are admitted. In community surveys, it is this group that is most difficult to reach."

In this study, we have attempted to consider all of the aspects of the follow-up process in a mass survey. While certain phases have been treated somewhat superficially, there is certainly conclusive evidence that an effective case finding program is being carried out. In order to make it even better, the problem areas suggested previously should be considered, not only by the official agency, the Bureau of Tuberculosis, but by the Tuberculosis Association, other groups concerned with tuberculosis control, and an informed and interested public. When the Tuberculosis

Bureau program has the support and understanding of the entire community, the problems of tuberculosis control will be dealt with constructively and effectively.

## THE CHEST HOSPITAL AS A PUBLIC INSTITUTION

ROBERT PERLSTEIN, M.D.\*

The Brompton Chest Hospital, oldest institution of its type, rounded out its first century of continuous service to the community of London in 1946. Of its origin, Clifford Hoyle says that about 1841, a "consumptive" clerk living in London found it impossible to obtain care in any of the then existing London hospitals. His predicament was brought to the attention of a young and public-spirited barrister and Member of Parliament, Philip Rose, who then organized a group whose aim was the erection of a hospital where tuberculous patients, rich or poor, could get the care they needed. Among the more famous sponsors of this project were members of the royal family, and such immortals as Jenny Lind and Charles Dickens. The tremendous practical results of this simple act of kindness are now discernible on every hand, for the tuberculosis hospital has been a very powerful weapon in the fight against this tenacious and family-destroying disease.

The role played by a hospital for tuberculous patients in any community has sharpened with the years. Beginning as Brompton did as a place where the patient with advanced disease could die with some semblance of human decency, the idea crystallized around the turn of the century that bed rest combined with a sound dietetic-hygienic regimen would result in arrest of the disease in certain cases. It was also perceived that since this was an infectious illness, the removal of sick patients from the community might diminish the spread of the disease. Thus to the primary aim of compassion were added those of isolation and cure. A little compassion, then, goes a long way. And after Koch's demonstration of the tubercle bacillus it was noted that the tuberculosis hospital provided an unexcelled place to study the disease scientifically and to train specialists in its treatment.

The Territory of Hawaii may be justly proud of its progressive outlook in health matters and not the least of these has been its modern and well considered approach to the treatment of tuberculosis. Leahi Hospital, the oldest of four such institutions in the Territory, was founded almost 50 years ago and is one of the oldest of such

\* Assistant Medical Director, Leahi Hospital, Honolulu.

hospitals in continuous operation in the United States. It originated as a "Home for Incurables," organized after the great plague epidemic of 1900. Its founders were the most prominent Honolulu citizens of their time and they aimed at nothing more spectacular than an act of kindness and humanity. It was natural in those days that among the first "incurables" admitted were patients with tuberculosis. These were quite literally incurable at the time, but with the knowledge gained from them the idea took shape that some were likely to recover. Which ones? This was the all important question which led to the next step in tuberculosis control. It became apparent that those who recovered were in the earlier stages of the disease, and this paved the way for an ever increasing campaign to discover tuberculosis in its earlier stages and to treat these people by hospitalization.

For the sake of brevity we must pass over the vast amount of knowledge acquired about accurate diagnosis, relapse and its prevention, x-ray interpretation, the physiology of the lungs, and such matters. An advantage of treating this disease in hospitals is that every patient, whether treated successfully or not, contributes his mite (or his all, if he dies) to the better understanding of his illness. And if he is cured he has acquired knowledge which he can pass on to others.

The modern tuberculosis hospital is no longer a "Home for Incurables." Its patients are treated and discharged much like those of its sister hospitals. Having the infection no longer carries the stigma that attached to it in the old days, and Leahi alumni are to be found in all circles of useful activity supporting themselves and their families without asking for special favors. Modern knowledge has increased the usefulness of the hospital beyond diagnosis, treatment and the training of medical and nursing personnel. It has become a center of education and the dissemination of knowledge among a wide circle of lay and professional people. It has advanced the knowledge of the surgical treatment of lung diseases. It carries its patients a long way toward rehabilitation even before discharge.

To meet all these demands Leahi Hospital is organized into many departments, each staffed by workers carefully chosen for their skill and training in their specialties. The group of physicians comprising the medical department consists of senior men trained in tuberculosis as their lifetime field, with a number of junior physicians who plan to make this their field of medical interest. Added to these are a group of consultants in every specialized field of medicine and surgery

who either hold regular clinics or are on call for patients who may require their expert knowledge. The hospital performs all medical and surgical treatment on its patients within its own walls, preferring this (as do the patients themselves) to the older method of sending such patients to general hospitals. The surgical staff consists of a full-time thoracic surgeon and a junior surgeon who perform the difficult and exacting lung operations which in modern times have revolutionized the treatment of tuberculosis almost as much as antibacterial therapy. The pharmacy under a competent pharmacist, the x-ray department and the laboratory department all work in close conjunction with the physicians and surgeons.

A large nursing department functions under a director of nursing and her assistant and is comprised of a number of graduate nurses, under whom a force of practical nurses and orderlies work. The hospital maintains as a community service a department of nursing education which gives modern courses to both graduate and undergraduate nurses. These courses are designed to acquaint the student with the most recent advances in medicine and surgery as they bear upon this disease. They are intensive, carefully prepared and organized, and fulfill a very important function in the community.

The social service department is of inestimable value in orienting a newly arrived patient to the hospital and in securing him against worries about family and financial matters. Whenever a problem arises with regard to any patient, a team consisting of the physician, the supervising nurse and the social worker attempt to solve it together. Here the social worker contributes her knowledge of the home and family to the solution of the problem. When the happy moment of discharge arrives, the social worker prepares the family, or finds a home if one is lacking. Her place, in short, is indispensable in the treatment of chronically ill patients.

Rehabilitation is the joint responsibility of the department which bears this name and of the occupational therapy department and the Leahi school and library. The patient is tested very shortly after arrival in the hospital if he is given a good prognosis by his physicians. His educational and occupational backgrounds are determined and steps are taken to amplify these so as to increase the patient's skills and knowledge. In this manner the time spent in the hospital is used to the patient's profit and advantage. Before discharge the patient's exercise tolerance is increased by work in some form of occupational therapy and the rehabilitation staff then plans for his re-



lease from the hospital. These plans may include training in an entirely new line of work or profession or return to the patient's earlier method of earning a livelihood.

Since 1931 the hospital has maintained its own out-patient department whose staff interviews, examines and x-rays more than 700 discharged patients yearly. Bearing in mind the relapsing nature of this disease, great care is exercised by the physician and his assistants to prevent breakdowns and to readmit and re-treat reactivating patients at the earliest moment when the opportunity is greatest for arresting the disease.

Finally one must emphasize the role played by the Administrator and his staff which includes the dietetic department and the business and maintenance groups. No well-run hospital can exist without careful planning and budgeting any more than it can get along without food, and this is particularly true of hospitals treating chronic illnesses. The food in particular must be wholesome, tasty and varied to interest patients who must stay a long time.

If this account of the service to the community offered by a tuberculosis hospital has been tedious and repetitious, the fault is mine. The design was simple. It aimed only to show the wide ramifications, not envisioned or expected at the time of its origin, of a simple act of human kindness.

### RESULTS OF ECONOMIC SECURITY BALLOT

Many of you are probably wondering just what the results were from the Economic Security ballot of this spring.

Some 491 ballots were mailed (total membership at that time) and not quite half of these were returned (237). Of these, one was declared void because it was incorrectly marked. In other words, only 48% of the membership voted. Of these, 84% voted yes and 16% voted no.

This means, then, that the general membership is not at this time willing to permit the Nurses' Association to act in their behalf to promote better economic conditions. This is evident by the small percentage of returns of the ballot (48%).

It seems that there was some misunderstanding as to the purpose of this ballot. If 51% of the general membership had returned a favorable vote, it would have meant simply this: If a group of nurses (members of the Association) had wished for and asked for assistance from their Association in obtaining better working conditions, etc., we would have been able to do so. It would give this Association the power to assist *only* where needed and *when* it was requested. Many groups

would not ever need such assistance—the industrial nurses, and those under civil service, probably, but those in the other fields might at some time in the future desire assistance in encouraging their employers to elevate their standards of work. It *does not* mean that this association would go right in and insist upon better working conditions, etc. It is intended to help when needed and requested.

As the matter stands now, it will have to rest until the fall meeting of the association.

### WE RECOMMEND

Tuberculosis Handbook for Public Health Nurses. Jean South, National Tuberculosis Association, 1950.

Safer Ways in Nursing. Joint Tuberculosis Nursing Advisory Service, National Tuberculosis Association, 1948.

Instruction Plan for Basic Tuberculosis Nursing. National League of Nursing Education, 1949.

Courses in Clinical Nursing for Graduate Nurses. Pamphlet No. 4. National League of Nursing Education, 1947.

The Management of Tuberculosis in General Hospitals. American Hospital Association, 1946.

The Modern Attack on Tuberculosis. H. D. Chadwick, M.D., and A. S. Pope, M.D. The Commonwealth Fund, 1946.

Tuberculosis, A Manual for Teachers. Grace T. Hallock, The Council of Tuberculosis and Health Association of Greater New York, 1948.

The Diagnosis and Treatment of Pulmonary Tuberculosis. Moses J. Stone, M.D., and Paul Dufault, M.D., Lea and Febiger, Philadelphia, 1946.

Nursing in Prevention and Control of Tuberculosis. H. W. Hetherington, M.D., and Fannie W. Eshleman, R.N., G. P. Putnam's Sons, New York, 1950.

Tuberculosis Among Children and Young Adults. J. A. Myers, M.D., Charles C. Thomas, Springfield, Illinois, 1946.

Pulmonary Tuberculosis in the Adult. Max Pinner, M.D., Charles C. Thomas, Springfield, Illinois, 1947.

Nursing in Tuberculosis. Louise Lincoln Cady, R.N., W. B. Saunders Co., Philadelphia, 1948.

Tuberculosis. Gerald Webb, M.D., Paul B. Hoeber, Inc., New York, 1948.

The Fundamentals of Pulmonary Tuberculosis. American College of Chest Physicians, Charles C. Thomas, Springfield, Illinois, 1949.

Handbook on Tuberculosis. W. H. Hatfield, M.D., Department of Health and Welfare of the Province of British Columbia, 1948.

An Autobiography. Edward Livingston Trudeau, M.D., Doubleday, Doran and Co., Inc., Garden City, New York, 1944.

Tuberculosis Nursing. Grace Longhurst, R.N., 2nd Edition, F. A. Davis Co., Philadelphia, Pa., 1947.

A Psychiatrist Looks at Tuberculosis. Eric Wittkower, M.D., The National Association for the Prevention of Tuberculosis, London, 1949.

Anderson, Robert J., and Blomquist, Edward T. Tuberculosis Control: A Total Program. Public Health Reports, Vol. 66, pp. 132-138, February 2, 1951.



**Vein-Sparing**

## **ALIDASE<sup>®</sup> IN SURGERY**

### **Preoperative, Operative, Postoperative—**

The complicating factors of venous thrombosis and "worn-out" veins have frequently made intravenous fluid administration a difficult and uncomfortable procedure.

The simplicity of subcutaneous fluid administration aided by Alidase (hyaluronidase) and the safety of this route make hypodermoclysis a valuable method for preoperative and postoperative fluid administration.

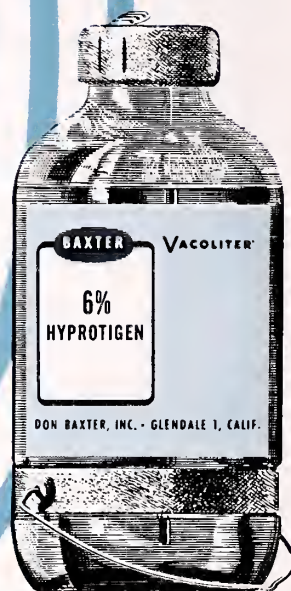
During surgery, Alidase-facilitated hypodermoclysis often offers the distinct advantage of permitting injection at a site remote from the surgical field and eliminates the cumbersome arm board. G. D. Searle & Co., Chicago 80, Illinois.



RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**



**6% HYPROTIGEN®**  
represents more  
protein per liter than  
any of the 3 leading  
protein hydrolyzates  
for parenteral use  
...yet Hyprotigen  
costs no more



**BAXTER**

**DON BAXTER, INC.**  
Research and Production Laboratories  
Glendale 1, California

*In addition to the usual rigid tests, each lot of  
Hyprotigen is subjected to clinical tests before release.*

**Territorial Distributor**  
**CROCKETT SALES COMPANY**

P. O. Box 3017, Honolulu, Hawaii • Phone 6-8992

### By Title, Subject and Author

<b>A</b>		Page
Alternating Bidirectional Tachycardia.....		186
Announcement:		
Sixty-First Annual Meeting, HTMA.....		298
Arioli, Peter E.		
Obituary .....		297
Arnold, Harry L., Jr.		
The President's Message.....		440

Berk, Morton F. (See Gotshalk, Henry C.)	
(Also see Molyneux, A. V.)	
Alternating Bidirectional Tachycardia.....	186
Blain, Daniel	
The Modern Psychiatric Hospital.....	177
Book Reviews.....	43, 121, 196, 290, 364, 446
Allison, S. D. ....	122
Arnold, H. L., Sr. ....	43, 196
Arnold, H. L., Jr. ....	44, 290, 368
Arthur, Philip S. ....	197, 368
Batten, G. A. ....	364
Beck, L. Clagett ....	46, 292
Bell, J. L. ....	46, 364, 366
Berk, Morton E. ....	121, 447
Bowles, H. E. ....	123
Brown, R. O. ....	291, 292
Buzaid, L. L. ....	123, 291
Carlucci, Angela M. ....	122
Casey, T. Alan ....	197
Chang, Clarence ....	364
Chang, Rosie K. ....	198
Cherry, James W. ....	292
Choy, Duke Cho ....	43
Chung, Mon Fah ....	450
Civin, W. Harold ....	196, 365, 368, 448
Cloward, Ralph B. ....	292
Cooper, John W. ....	197
deHay, Raymond W. ....	43, 46, 364, 449
Domzalski, C. A., Jr. ....	122, 446, 447
Draper, Laura A. ....	198
Enright, James R. ....	45, 366, 448
Frazer, John P. ....	367
Fujiwara, T. F. ....	365
Giles, F. L. ....	44
Gordon, Maurice ....	368
Gotshalk, Henry C. ....	291
Halpern, G. M. ....	290
Hartwell, Alfred S. ....	197
Holmes, William John ....	196, 197
Hu, Stephen M. K. ....	365
Irwin, P. S. ....	367
Ishiki, Yetta ....	45
Kobayashi, C. K. ....	447
Koenig, Elizabeth H. ....	43, 45

	Page
Larsen, Ivar J. ....	123, 367
Larsen, Nils P. ....	122
Leedham, Charles L. ....	449
Lowrey, John J. ....	46, 196, 197, 290, 447
Majoska, Alvin V. ....	124
Mallen, Margaret ....	448
Marnie, James G. ....	367
McCorriston, C. C. ....	43, 124
Medeiros, Isabel M. ....	45
Mermod, Leon E. ....	447
Moffat, H. F. ....	446
Molyneux, A. V. ....	365, 446
Nance, F. D. ....	198
Nishijima, Satoru ....	364
Pang, L. Q. ....	291
Peyton, John H. ....	365
Quisenberry, Walter B. ....	123, 449
Rhead, Clifton C. ....	367
Richardson, B. Allen ....	447
Rusch, Kenneth H. ....	123, 196
Schiffman, Bertha ....	121, 291, 449, 450
Simon, H. Joseph ....	44
Spencer, Frank C. ....	121
Stevens, Marquis E. ....	448
Stevens, William H. ....	43, 44
Stewart, S. F. ....	43
Stubblefield, Esther M. ....	366
Tom, K. S. ....	121
Waite, V. C. ....	124, 196, 446
White, J. Warren ....	198, 290
Withington, Paul ....	368
Wong, Wayne W. ....	124, 364
Wong, Y. T. ....	448
Yee, Lester ....	290
Brown, Samuel R. Hodgkin's Disease Controlled by Chloromycetin....	356

Carcinoma of the Stomach in Hawaii, Observation On.....	173
Cloward, Ralph B. Subdural Hematoma .....	183
Connor, Angie (See Yoshina, Teruo) Rheumatic Fever in Hawaii.....	181
Correlation of Laboratory Data with Renal Disease..	279
County Societies (See Reports)	

Declaration of Geneva.....	190
Domzalski, C. A., Jr.	
Medical News.....	40, 119, 287, 361



	Page
<b>E</b>	
Editorials.....	37, 117, 193, 285, 359, 441
ACTH and Cortisone May be Bad for Tuberculosis .....	441
Advertising Versus Announcements.....	38
Antibiotics Don't Help Zoster—Yet.....	442
BCG Vaccine .....	359
Cancer Society's Cytology Service.....	38
Congratulations, General Practitioners! .....	360
Cortisone For Burns.....	285
"Free" Choice of Physician in England.....	286
Give to the AMA Educational Foundation.....	441
Happy Hundredth Birthday, Board of Health! .....	194
International Code of Medical Ethics.....	194
Join the American Medical Association Now! .....	193
Modern Treatment of Burns.....	193
No "Closed Shop" for Doctors.....	286
Oregonized Medicine Gets Green Light.....	118
Parathion Poisoning .....	117
Post-Partum Plasma .....	286
"Probably Benign" Equals "Possibly Malignant".....	194
"Psychogenic" Doesn't Mean "Functional".....	39
Samuel Sorbier and the Alarm Reaction.....	118
Sulfone Treatment of Leprosy.....	442
Terms of Slavery.....	360
The Hiscock Report, 1950.....	117
The Leahi Hospital Report, 1950.....	360
The Medical Library is Ready to Serve You.....	286
Toxoplasmosis in Hawaii.....	37
What's In a Name? .....	442
Your AMA Dues.....	39
Effect of Penicillin Upon Bacteremia Following Tooth Extraction .....	432

<b>F</b>	
Fanning, Captain Robert J., D.D.S., USA	
The Effect of Penicillin Upon Bacteremia Following Tooth Extraction.....	432
Food Values of Hawaiian Grown Fruits and Vegetables .....	34
Freeman, G. C.	
A Study of Thyroid Disease in Hawaii.....	27
Fujiwara, T. F.	
Hypersplenism .....	429

<b>G</b>	
Gebauer, Paul W.	
Tuberculous Bronchostenosis, Pathology and Treatment .....	423
Gotshalk, Henry C. (See Berk, Morton E.)	

<b>H</b>	
Hamilton, Hugh C. (See Higgins, Robert S.)	
Blood Changes in Pregnancy.....	274
Hartwell, A. S. (See Reports—Delegates')	
Hawaii Cancer Society Services to Physicians.....	299
Hawaii Medical Service Association.....	206
Hematological Serum Protein Changes Occurring in Uncomplicated Pregnancy.....	274
Herter, W. B.	
What's In a Name? (Editorial).....	444

Higgins, Robert S. (See Hamilton, Hugh G.)	
Hill, Dr. Rogers Lee	
The President's Page.....	116, 192
Venous Thrombosis and Pulmonary Embolism....	283
Hiscock, Ira V.	
Public Health in Hawaii, 1950.....	99
Hodgkin's Disease Controlled by Chloromycetin.....	356
Hypersplenism .....	429

<b>I</b>	
Index to Advertisers.....	78, 154, 226, 322, 398, 494
International Code of Medical Ethics.....	190
Intra-abdominal Neurogenic Sarcoma.....	353
Izumi, Homer F. (See Reports—Delegates')	

<b>L</b>	
Laboratory Data in Renal Disease.....	279
Library Reports.....	41, 120, 195, 289, 362, 445

<b>M</b>	
Marks, Robert H.	
ACTH and Cortisone May be Bad for Tuberculosis (Editorial).....	441
Medical News.....	40, 119, 287, 361
Milford, John James, Jr.	
Obituary .....	375
Miller, Carey D.	
Food Values of Hawaiian Grown Fruits and Vegetables .....	34
Milnor, Guy Champion	
Obituary .....	129
Mizuire, S.	
Sulfonamide Nephrosis and Its Treatment.....	350
Modern Psychiatric Hospital.....	177
Mori, Iga	
Obituary .....	454
Molyneux, A. V. (See Berk, Morton E.)	
The Correlation of Laboratory Data with Renal Disease.....	279

<b>N</b>	
Norman, Mabelclaire R.	
Executive Secretary's Message....	59, 138, 208, 305, 382
Notes and News.....	53, 128, 203, 296, 374, 453
Nurses:	
A.N.A. Nationwide Study.....	136
Annual Convention.....	133, 134, 136
Be Professional .....	385
Biennial Convention, 1952.....	214
Blood Donors Wanted.....	213
Cancer Institutes.....	66, 211
Civilian Defense Training for Nurses.....	214
Current Information on Wage Stabilization.....	382
Editorials .....	212, 303
Executive Secretary's Message....	59, 138, 208, 305, 382
Fear and How to Cope With It.....	208
Hawaii Students Rank High in State Boards.....	60
Hobby Corner.....	307, 385
Impressions of a Malihini.....	301

	Page		Page
In-Service Staff Education Program.....	138	Prolapsing Redundant Gastric Mucosa.....	267
Keeping Up With Medicine.....	61	Public Health in Hawaii, 1950.....	99
Message from the New President.....	137		
Money Management for Nurses.....	302	<b>Q</b>	
NATH Membership Drive.....	385	Quisenberry, Walter B. (See Spencer, Frank L.)	
New Officers.....	305		
News Notes—Here and There.....	64, 139, 308	<b>R</b>	
Nurses Ask Wage Board Support.....	382	Repair of Unilateral Cleft Lip.....	343
Nurses' Association, District of Oahu.....	214	Reports:	
Nurses Recruited for Disaster Program.....	60	County Societies:	
Oahu Public Health Nurses Organize.....	305	Hawaii.....	47, 125, 200, 293, 369, 451
Opinionnaire.....	212	Honolulu.....	48, 125, 201, 293, 370, 451
Platform for Nurses' Association, Territory of		Kauai.....	48, 125, 202, 295, 371, 451
Hawaii.....	133	Maui.....	49, 126, 202, 295, 372, 452
Poems.....	141, 307	Territorial Medical Association	
Polio Nursing Care Institute.....	62	Annual Meeting.....	458
Practical Nurses.....	64, 214	Council.....	199
Red Cross:		Delegate's Report, AMA Meeting,	
Courses to be Given.....	60	San Francisco.....	50
Nursing Service—How to Enroll.....	61	Delegate's Report, AMA Meeting,	
Share in Program.....	304	Atlantic City.....	443
Relation of ANA Research to Present Survey		Supplement to Delegate's Report.....	444
in Hawaii.....	306	Hawaii Cancer Society Cytology Laboratory.....	437
Reports:		Rheumatic Fever in Hawaii.....	181
Condensed Report of Nursing Study			
Committee.....	379	<b>S</b>	
NATH President at ANA Meeting.....	306	Spencer, Frank C. (See Tilden, I. L. and	
White House Conference.....	384	Quisenberry, W. B.)	
Results of Economic Security Ballot.....	482	Report of Hawaii Cancer Cytology Laboratory....	437
School Nurse Section.....	213	Strode, J. E.	
Social Security.....	137, 212	Observations on Carcinoma of the Stomach in	
Student Nurses' Organization.....	63	Hawaii.....	173
Student Recruitment.....	307	Study of Thyroid Disease in Hawaii.....	27
Tenth Anniversary Mabel L. Smyth Memorial		Subdural Hematoma.....	183
Building.....	207	Sulfonamide Nephrosis and Its Treatment.....	350
The Nurse in Atomic Warfare Disaster.....	383	Summary of Management of Burn Patient.....	191
Thompson, Mrs. Arlene, Appointed to ANA		Surgeon's Responsibility in Care of Cancer Patient....	19
Committee.....	60		
Tuberculosis:		<b>T</b>	
A Follow-up Study of Mass X-ray Survey.....	478	Tilden, I. L. (See Spencer, Frank C.)	
Isolation Technics in Tuberculosis Nursing.....	475	Tuberculous Bronchostenosis, Pathology and	
Local Diagnostic Facilities in Tuberculosis.....	476	Treatment.....	423
The Chest Hospital as a Public Institution.....	480		
We Recommend.....	482	<b>V</b>	
You Would Enjoy.....	307	Venous Thrombosis and Pulmonary Embolism.....	283
		Vitamin Deficiencies and Disease.....	347
<b>O</b>			
Obituaries:		<b>W</b>	
Arioli, Peter E. ....	297	Wade, Burt O.	
Milford, John James, Jr.....	375	Intra-abdominal Neurogenic Sarcoma.....	353
Milnor, Guy Champion.....	129	Waite, V. C.	
Mori, Iga.....	454	Primary Anorectal Abscess.....	113
		Washko, Peter J.	
<b>P</b>		Prolapsing Redundant Gastric Mucosa.....	267
Pack, George T.			
The Surgeon's Responsibility in the Care of the		<b>Y</b>	
Cancer Patient.....	19	Yoshina, Teruo (See Connor, Angie)	
Pan-Pacific Surgical Congress.....	37, 359, 441		
Pang, L. Q.			
Repair of Unilateral Cleft Lip.....	343		
Patterson, William B.			
Vitamin Deficiencies and Disease.....	347		
President's Page, The.....	116, 192, 440		
Primary Anorectal Abscess.....	113		



# **D**efense is your job, too—how to help your country now

## **TEAM UP WITH THESE TYPICAL AMERICANS IN THE PAYROLL SAVINGS PLAN!**



★ **Pasquale Santella**, millwright at United States Steel Company's Carrie Furnaces of the Homestead District Works, has a very personal reason for buying Savings\* Bonds. To **C. F. Hood**, United States Steel Company executive vice president, he says, "My son Tony, 19, is missing in Korea. Used to be I bought bonds because it was my duty and it was a good way to save money. Now I want to help lick the Reds and get Tony back. I buy one bond every payday and when Uncle Sam needs more money, I'll buy *more* bonds." He has bought bonds regularly since 1943, has never cashed one.

*\* U.S. Savings Bonds are Defense Bonds  
Buy Them Regularly!*

TODAY join with other Americans—business leaders and employees—in their drive to make our country and our citizens more secure. If you're an employee, go to your company's pay office *now* and start buying U. S. Defense Bonds through the Payroll Savings Plan—the safe, sure way to save for defense and for personal dreams-come-true.

If you're an employer, and have not yet installed the easily handled Plan, you will soon be contacted by one of industry's leading executives. Sign up with him—and help him put the Plan in every company! It's a practical way to help preserve our nation's future, its fortune, and the very institutions that make our lives worth while!

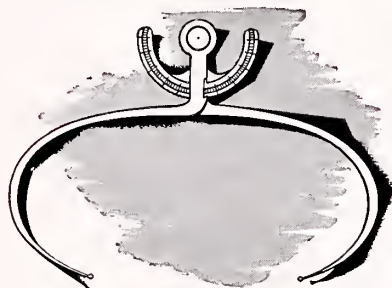


*Your Government does not pay for this advertising. It is donated by this publication in cooperation with The Advertising Council and the Magazine Publishers of America.*

*Effective against many bacterial and rickettsial infections,  
as well as certain protozoal and large viral diseases.*

# AUREOMYCIN

*Hydrochloride Crystalline*



**The Obstetrician** is daily finding aureomycin an increasingly valuable agent for the prevention and treatment of infection. It may be given to advantage prophylactically in long and difficult labors and in all operative deliveries or infected abortions. Aureomycin not only attacks the maternal disease but also, by its passage in therapeutic concentrations into the placental circulation, treats possible infection in the child before and during birth. Aureomycin has proved its usefulness in endometritis, parametritis, urinary infection, infected thrombophlebitis and other infections, caused by a wide variety of organisms. Aureomycin is a drug indispensable to obstetric practice.

#### *Packages*

*Capsules:* Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.

*Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION

*AMERICAN Cyanamid COMPANY*

30 Rockefeller Plaza, New York 20, N. Y.

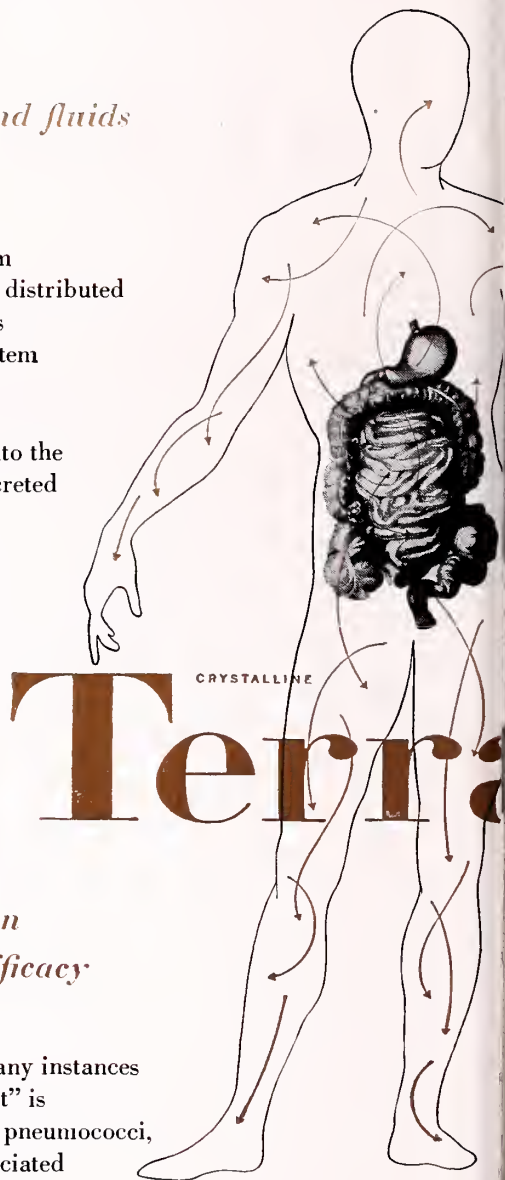


## IN THE SELECTION OF AN ANTIBIOTIC

*distribution in body tissues and fluids  
may be a vital factor*

Terramycin is rapidly absorbed from the gastrointestinal tract and widely distributed in body fluids and tissues. It appears to be concentrated in the hepatic system and excreted in the bile.

Terramycin rapidly traverses the placental membrane, and diffuses into the pleural fluid. Large amounts are excreted unchanged in active form in urine and feces, and oral intake markedly alters the intestinal flora.<sup>1,2</sup>



*a broad antimicrobial spectrum  
widens the range of clinical efficacy*

Favorable response, described in many instances as "excellent," "good," and "prompt" is recorded for bacteremias caused by pneumococci, staphylococci, and streptococci associated with pneumonia, meningitis, endocarditis, urinary infection, septic arthritis and pneumonitis.<sup>2,4,5,6,7,8,9</sup>

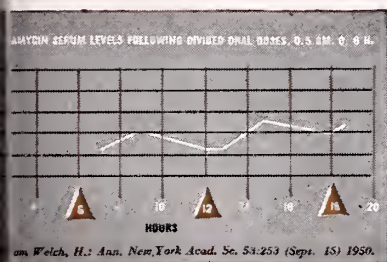
Acute brucellosis, and Bacteroides and E. coli bacteremias have responded favorably,<sup>2,10,11</sup> as have the commonly encountered rickettsioses.<sup>12</sup>

Antibiotic Division

Pfizer

# OR USE IN SYSTEMIC INFECTIONS

therapeutic serum levels  
rapidly achieved  
and easily maintained } are a critical requirement



Terramycin has relatively high stability in serum. Therapeutic levels are rapidly achieved and easily maintained by oral administration. Detectable amounts have appeared in the serum within one-half hour, and have been observed as long as twenty-four hours following a single 2 Gm. dose.<sup>1</sup> When divided doses (0.5 Gm. q. 6 h.) are given, effective serum concentrations are obtained, as shown in the accompanying chart.<sup>3</sup>

# mycin

HYDROCHLORIDE



## The growing literature

continues to stress:

The broad-spectrum activity of Terramycin against organisms of the bacterial and rickettsial as well as certain protozoan groups.

The promptness of response to Terramycin in acute and chronic infections involving a wide range of systems, organs and tissues.

Crystalline Terramycin Hydrochloride is available as: Capsules, Elixir, Intravenous, Ophthalmic Ointment, Ophthalmic Solution.

1. Schoenbach, E. B.; Bryer, M. S., and Long, P. H.: Ann. New York Acad. Sc. 53:245 (Sept. 15) 1950.
2. Herrell, W. E.; Heilman, F. R., and Wellman, W. E.: Ann. New York Acad. Sc. 53:448 (Sept. 15) 1950.
3. Welch, H.: Ann. New York Acad. Sc. 53:253 (Sept. 15) 1950.
4. Hubbard, W. N., Jr., and Tillet, W. S.: Ann. New York Acad. Sc. 53:429 (Sept. 15) 1950.
5. Timpanelli, A.; Huebner, R. D., and McDermott, W.: Ann. New York Acad. Sc. 53:440 (Sept. 15) 1950.
6. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: J.A.M.A. 143:1 (May 6) 1950.
7. Finland, M.; Goeke, T. M.; Jackson, G. G.; Womack, C. R., and Kass, E. H.: Ann. New York Acad. Sc. 53:290 (Sept. 15) 1950.
8. Bauer, R. E.; Parker, R. T.; Hall, H. E.; Benson, J. F.; Joslin, B. S.; Hightower, J. A.; Snyder, M. J.; Venable, S. J., and Woodward, T. E.: Ann. New York Acad. Sc. 53:395 (Sept. 15) 1950.
9. Blake, F. G.; Friou, G. J., and Wagner, R. R.: Yale J. Biol. and Med. 22:495 (July) 1950.
10. Knight, V.: New York State J. Med. 50:2173 (Sept. 15) 1950.
11. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.
12. Keefer, C. S.: Ann. New York Acad. Sc. 53:223 (Sept. 15) 1950.



## NORM

Normal schedule of development (auxodrome) plotted on Wetzel Grid.<sup>1</sup>

## CURVE A

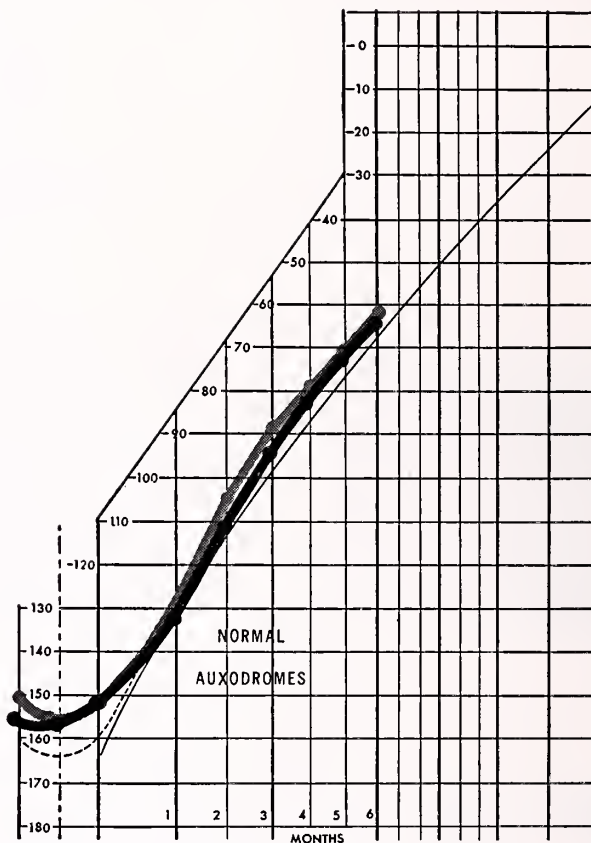
Composite Wetzel Grid auxodrome of 60 unselected infants on S-M-A from birth to 6 months of age.

## CURVE B

Growth data, recomputed on Wetzel Grid, based on "selected subjects, most of whom were favored by environment;"<sup>2</sup> age: from birth to 6 months.

1. Wetzel, N. C.:  
J. Pediat. 29:439,  
1946.

2. Jackson, R. L.,  
and Kelly, H. G.:  
J. Pediat. 27:215,  
1945.



*Comparative development rates prove...*

# S-M-A<sup>®</sup>

*builds husky babies*

Recent clinical studies of development rates of *unselected* S-M-A-fed babies (curve A on chart) prove its value. The growth results compare favorably with "standards which are considered to approach the optimum for general pediatric practice."<sup>2</sup> (curve B on chart).

Because it is patterned after human milk **S-M-A<sup>®</sup>**

with Vitamin C added  
is recognized as an outstanding food for babies.



Wyeth Incorporated, Philadelphia 2, Pa.





"Premarin"—a naturally occurring conjugated estrogen which has long been a choice of physicians treating the climacteric—is earning further clinical acclaim in the treatment of functional uterine bleeding.

The aim of estrogenic therapy in functional uterine bleeding is to bring about cessation of bleeding, and to produce subsequent regulation of the cycle. Once hemostasis is achieved, the maximum daily dosage of "Premarin" must be continued to prevent recurrence of bleeding. This schedule forms part of cyclic estrogen-progesterone treatment for attempted salvage of ovarian function.

"Premarin" contains estrone sulfate plus the sulfates of equilin, equilenin,  $\beta$ -estradiol, and  $\beta$ -dihydroequilenin. Other  $\alpha$ - and  $\beta$ -estrogenic "diols" are also present in varying amounts as water-soluble conjugates.



An "estrogen of choice  
for hemostasis  
is 'Premarin'  
in tablets of 1.25 mg. ...  
The usual dose for hemostasis  
is 2 tablets three times a day.  
If bleeding has not decreased  
definitely by the third day of  
treatment the dosage level  
may be increased by  
50 per cent."\*

\*Fry, C. O.: J. Am. M. Women's A. 4:51 (Feb.) 1949

## "PREMARIN"®

*Estrogenic Substances (water-soluble)  
also known as Conjugated Estrogens (equine)*

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

Ayerst, McKenna & Harrison Limited  
22 East 40th Street, New York 16, N. Y.



# Dollars that stay in Hawaii

*...more than 14 MILLION a Year!*



## For the Fleet

When you realize that Matson's fleet of freighters and the Lurline make more than 200 sailings in and out of Honolulu yearly, it is not surprising that last year they spent \$8,855,000. These dollars, *staying in the islands*, included payments for stevedoring services, supplies, docking fees and miscellaneous expenses.



## For the Hotels

The Royal Hawaiian and the Moana spent \$4,097,000 in 1950 for *local* purchases, wages, supplies and taxes. When the SurfRider is completed in November, more dollars will go to work in Hawaii.



## For Offices

The executive offices, the passenger offices and handling of Company details in the islands expended another \$460,000. This sum included items of direct support, such as \$50,000 contributed to the Visitors Bureau.



## For Crew Wages, Etc.

Many crew members live in Hawaii. Their wages, together with estimated expenditures by crews, "going ashore" in their regular visits here, totaled some \$650,000 last year.

**Matson**  
spends in the  
Islands

**\$1,171,834 every month**  
**...or \$38,526 every day**  
**...or \$1,605 every hour**

*Matson Lines*  
Pier 9 Honolulu



## INDEX TO ADVERTISERS

	PAGE		PAGE
Abbott Laboratories .....	495	Merck & Co., Inc. ....	411
Ar-Ex Cosmetics, Inc. ....	438	Parke, Davis & Company.....	402, 403
Ayerst, McKenna & Harrison, Ltd. ....	493	Pet Milk Company .....	406
Borden Company .....	422	Pfizer & Co., Inc. ....	490, 491
Brainard and Black, Ltd. ....	474	Philip Morris & Co., Ltd., Inc. ....	408
Carnation .....	409	Sandoz Pharmaceuticals .....	456
Dairymen's .....	418	Schering Corporation .....	405
Don Baxter, Inc. ....	412, 484	Schuman Carriage Company .....	416
Eli Lilly & Company .....	401, Insert	Searle & Co. ....	483
Hawaiian Electric Co., Ltd. ....	410	Sharp & Dohme .....	414, 415
Home Insurance Company .....	452	Squibb .....	439
Hotel Import Company .....	420	Upjohn .....	407, 413
Lederle Laboratories .....	489	U. S. Treasury.....	488
Matson .....	494	Wander Company .....	404
McArthur & Summers .....	457	Winthrop-Stearns, Inc. ....	417
Mead Johnson & Co. ....	496	Wyeth Incorporated .....	419, 492



**MORE** **HOURS** of Allergy Relief...  
**8 to 24 from**  
**a single dose**

Look in the file of clinical reports on antihistaminics and it will be apparent that one is outstanding for prolonged action. It is DI-PARALENE Hydrochloride (Chlorcyclizine Hydrochloride, Abbott), a "different" antihistaminic with a piperazine side chain rather than one of the conventional types.

Numerous clinical reports attest to the longer lasting allergy relief with DI-PARALENE. In many cases relief up to 24 hours can be obtained from a single dose. Initially, DI-PARALENE should be administered in 50-mg. doses three times a day for the average adult, but in the majority of cases this dosage can later be reduced to one or two doses a day. One 50-mg. tablet at bedtime often provides symptomatic relief through the night. Frequently, no additional dosage is required until the next bedtime. Undesirable side-effects are comparatively few and mild.

This season try longer-acting DI-PARALENE in your allergy cases. Available at prescription pharmacies in 50-mg. and 25-mg. tablets in bottles of 100 and 500. **Abbott**

*Specify*

Abbott's new long-acting  
 antihistaminic



**REFERENCES:** Spielman, A. D. (1950), N. Y. St. J. Med., 50:2297, Oct. 1. Brown, E. A., et al. (1950), Ann. Allergy, 8:32, Jan.-Feb. Jenkins, C. M. (1950), J. Nat. Med. Assn., 42:293, Sept. Cullick, Louis, and Ogden, H. D. (1950), South. Med. J., 43:632, July. Ehrlich, N. J., and Kaplan, M. A. (1950), Ann. Allergy, 8:682, Sept.-Oct.



*For new variety in flavor. . . . for wider clinical usefulness*

# The PABLUM family now includes 4 precooked infant cereals



Under the one trusted name PABLUM®, physicians may now prescribe *four* precooked infant cereals.

The original Pablum, world's first precooked enriched cereal, is now PABLUM MIXED CEREAL. Pabena® is now PABLUM OATMEAL. And two new Pablum cereals are available—PABLUM BARLEY CEREAL and PABLUM RICE CEREAL.

A new manufacturing process brings out the full, rich flavor of all the Pablum cereals.

The new Pablum packages, designed for superior protection, safeguard flavor and freshness.

Only Pablum cereals have the convenient "Handy-Pour" spout that opens and closes with a flick of the finger.

Pablum Oatmeal, Barley and Rice cereals provide welcome flavor variety and find application when the physician prefers a single grain cereal.

If allergies are involved, Pablum Rice Cereal is especially valuable—not only for infants but for older patients.

Behind all four Pablum Cereals are the experience and reputation of Mead Johnson & Company, pioneers in nutritional research for almost half a century.



**MEAD JOHNSON & CO.**  
EVANSVILLE 21, IND., U.S.A.



# HAWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

OCT 19 1951

LIBRARY

SEPTEMBER-OCTOBER, 1951

NUMBER 1

ZINC SULFATE TURBIDITY TEST IN HEPATOBILIARY DISEASE Elizabeth K. Anderson and W. Harold Civin.....	17
ANTIDOTES FOR DESTRUCTION F. J. Halford.....	19
DENTAL CARIES AMONG SCHOOL CHILDREN IN HAWAII Robert J. Fanning.....	22
FEATURES .....	25
INTER-ISLAND NURSES' BULLETIN.....	45

## REMEMBER THIS TERM?



Very likely you would if you had practiced  
in 1876, when lantern parades and street fights were popular forms  
of entertainment—and Eli Lilly and Company had just begun.

Then the prescription for a *hirudo*, or leech, was the preferred  
treatment for a "black eye." In contrast, studies today are bent  
upon conquering the more serious vascular  
disorders. Research of this kind has made  
real progress in the Lilly Laboratories.



*Lilly*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.





PARKE, DAV

World-wide **USE**  
World-wide **ACCLAIM**

# Chloromycetin<sup>®</sup>

CHLOROMYCETIN's world-wide reputation stems from its ability to produce rapid clinical response in a wide variety of infectious diseases—bacterial, viral and rickettsial. Numerous reports and the experience of daily practice confirm its

*clinical efficacy • high tolerance*  
*wide spectrum • high blood levels*

CHLOROMYCETIN, a pure crystalline compound of definite molecular structure, is the only antibiotic produced on a practical scale by chemical synthesis. This unique feature means unvarying composition for dependable therapeutic results, freedom from extraneous material, and infrequent side effects.

CHLOROMYCETIN (Chloramphenicol, Parke-Davis) is supplied in Kapseals<sup>®</sup> of 250 mg., and in capsules of 50 and 100 mg.

**COMPANY** DETROIT 32, MICHIGAN







*In Soft-tissue Infections:* "Terramycin was used in [101] soft-tissue infections and proved to be of great value... Where the terramycin was used intravenously with the proper diluent, no instance of chemical phlebitis occurred....Where surgical intervention was used in conjunction with terramycin, the decrease in morbidity was marked and noteworthy...That terramycin has a wide and useful area of great value in the treatment of soft-tissue infections is beyond question."

*Wright, L. T., et al.: Antibiotics and Chemotherapy 1:165 (June) 1951.*

ANTIBIOTIC DIVISION



amycin is also indicated in a wide range of

# **GRAM-POSITIVE BACTERIAL INFECTIONS**

*Lobar pneumonia • Mixed bacterial pneumonias*  
*Bacteremia and septicemia*  
*Acute follicular tonsillitis*  
*Septic sore throat • Pharyngitis*  
*Acute and chronic otitis media*  
*Acute bronchitis • Laryngotracheitis*  
*Tracheobronchitis • Sinusitis*  
*Chronic bronchiectasis*  
*Pulmonary infections associated*  
*with pancreatic insufficiency*  
*Scarlet fever • Urinary tract infections*  
*Acute and subacute purulent conjunctivitis*  
*Acute catarrhal conjunctivitis*  
*Chronic blepharoconjunctivitis*  
*not involving the meibomian gland*  
*Abscesses • Cellulitis*  
*Furunculosis • Impetigo*  
*Infections secondary to Acne vulgaris*  
*Erysipelas • Peritonitis*

# **GRAM-NEGATIVE BACTERIAL INFECTIONS**

*Gonorrhea • Brucellosis*  
*Bacteremia and septicemia*  
*Friedländer's pneumonia*  
*Mixed bacterial pneumonias*  
*Pertussis • Diffuse bronchopneumonia*  
*Post-partum endometritis • Granuloma inguinale*  
*Dysentery • Urinary tract infections*  
*Respiratory tract infections*  
*Cellulitis • Peritonitis • Tularemia*

# **SPIROCHETAL INFECTIONS**

*Syphilis • Yaws • Vincent's infection*

# **RICKETTSIAL INFECTIONS**

*Epidemic typhus • Murine typhus*  
*Scrub typhus • Rickettsialpox*  
*Q fever • Rocky Mountain spotted fever*

# **VIRAL INFECTIONS**

*Primary atypical pneumonia (virus pneumonia)*  
*Lymphogranuloma venereum • Trachoma*

# **PROTOZOAL INFECTIONS**

*Amebiasis*

able as

ULES

IR

R. DROPS

AVENOUS

PHALMIC

MENT

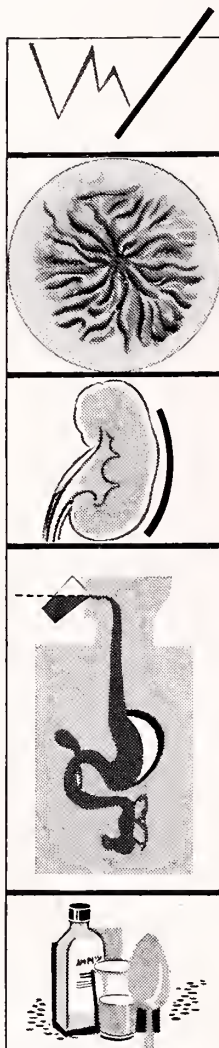
PHALMIC

OTION





FOR THE PEPTIC ULCER PATIENT  
 "DOUBLE-GEL ACTION" **AMPHOJEL**



relieves pain promptly

stops gastric corrosion

promotes rapid healing

provides a soothing protective coating over the ulcer

no kidney damage

imposes no added burden on kidney function

never causes alkalosis

buffers gastric contents moderately; permits normal neutralization of alkaline secretions of upper intestine

no acid rebound

even in excessive doses. Does not cause unphysiologic alkalinity and consequent acid secretory response

pleasant to take

smooth, creamy, pleasing taste and texture



SUPPLIED: Liquid, bottles of 12 fl. oz. Also available: Tablets of 5 grains and 10 grains

After 15 years of clinical use, the most widely prescribed medication for peptic ulcer—



**AMPHOJEL<sup>®</sup>**

ALUMINUM HYDROXIDE GEL • ALUMINA GEL WYETH

*Wyeth* Incorporated, Philadelphia 2, Pa.



## An Unsurpassed Estrogen Therapy

Small dosage makes ESTINYL inimitable among orally effective estrogens. As little as *two hundredths of a milligram daily* relieves menopausal symptoms and produces a sense of well-being obtainable only with larger doses of other estrogens.

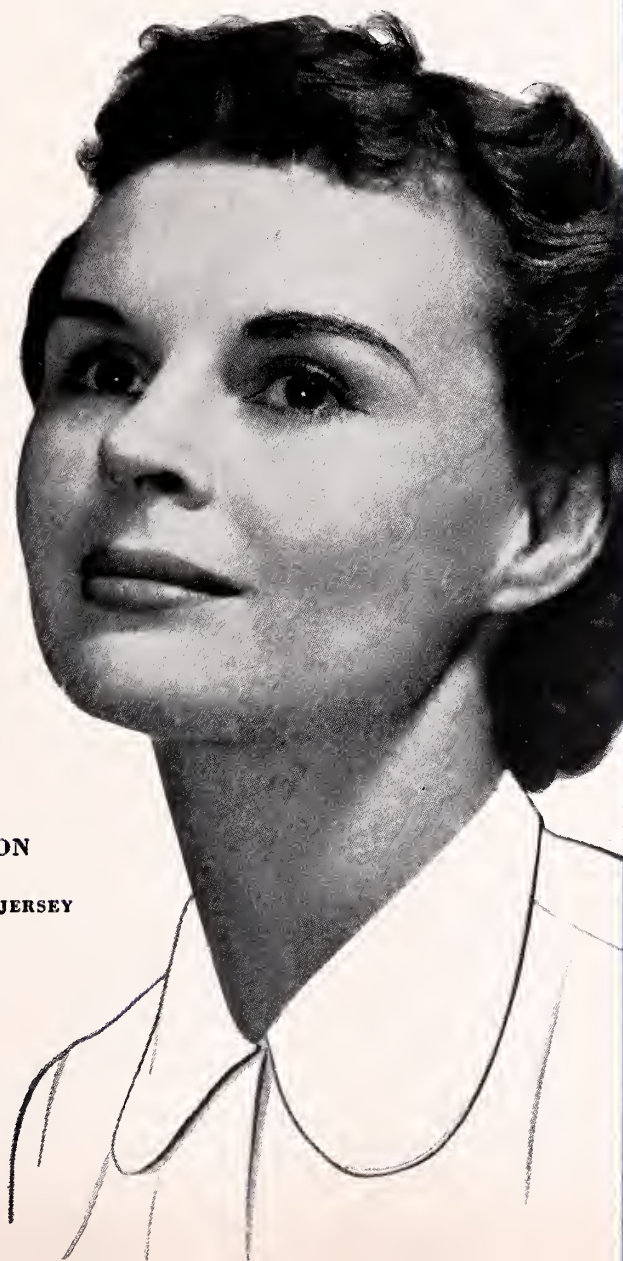
# ESTINYL®

(ethinyl estradiol-Schering)

Available for treatment of menopause and other estrogen deficiency states, in tablets of 0.02, 0.05 and 0.5 mg.

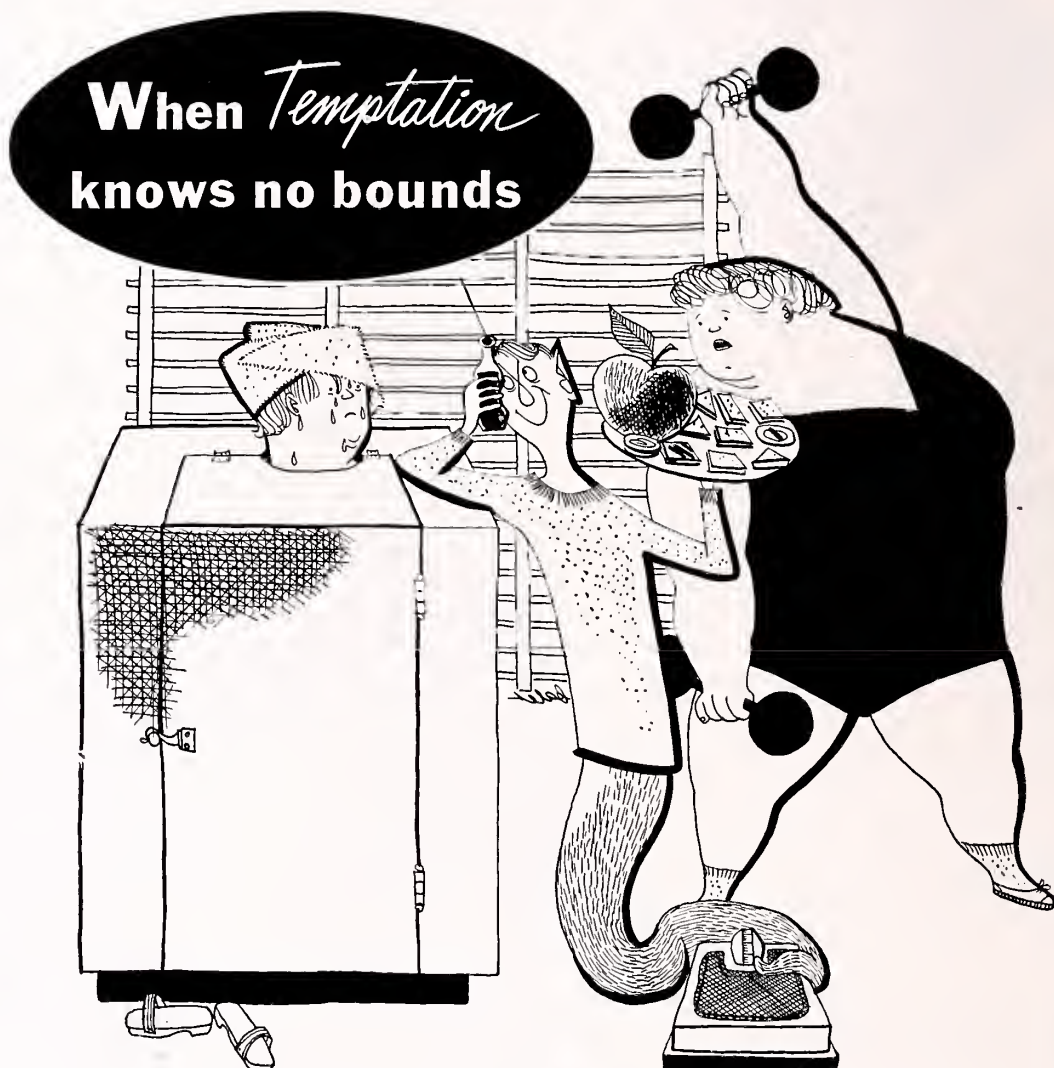
*Schering* CORPORATION

BLOOMFIELD • NEW JERSEY



# ESTINYL





A valuable adjunct to the dietary regimen is DESOXYN Hydrochloride—to dull the sensation of hunger, buoy the spirits, help make the patient a better match for temptation. Weight for weight, DESOXYN is more potent than other sympathomimetic amines so that *smaller doses* can produce the desired anorexia. With the recommended dosage there is *seldom any side-effect* or feeling of "drug stimulation." One 2.5-mg. or 5-mg. tablet before breakfast and another about an hour before lunch are usually sufficient. In addition, DESOXYN has a *faster action, longer effect*. Try it—in obesity and in other conditions indicating an effective central stimulant.

Abbott

Prescribe

## DESOXYN<sup>®</sup> Hydrochloride

(METHAMPHETAMINE HYDROCHLORIDE, ABBOTT)

TABLETS

2.5 and 5 mg.

ELIXIR

2.5 mg. per  
fluidrachm

AMPOULES

20 mg.  
per cc.



every  
drop  
the  
same  
high  
quality



**...because of Carnation's unique  
COW-TO-CAN CONTROL**

If the can bears the Carnation label,  
you can be absolutely sure that  
*...every drop of milk has been processed  
with prescription accuracy  
...in Carnation's own plants under  
Carnation's own supervision.*

This complete cow-to-can control is your assurance that  
every drop of Carnation is the same high quality, *always*.  
And it's our way of protecting your recommendation.

We believe this is the reason why  
8 out of 10 mothers who use Carnation Milk say,  
"My doctor recommended it."

**THE MILK EVERY DOCTOR KNOWS**



*"From Contented Cows"*



## *A Medical Man . . .*

. . . Wrote the first Life Insurance Policy in Hawaii in October, 1851—just 100 years ago, according to available records.

He was Dr. Gerrit P. Judd, one of our early medical missionaries and first member of one of Hawaii's First Families. The policy was the 3,630th issued by New England Mutual since its charter in 1835. Dr. Judd was the N.E.M. agent here for a number of years.

## **NEW ENGLAND MUTUAL LIFE**

**Insurance Company of Boston**

*100th Year of Service in Hawaii*

**GENERAL AGENT**

**HOME INSURANCE CO. OF HAWAII, LTD.**

Honolulu . . . King St. between Fort & Bishop

Mauī—Lufkin Ins. Agency . . . . . Wailuku

Kauai—J. M. Lydgate, Ltd. . . . . Lihue

## *Relationship of Stress to Autonomic Lability*

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance.<sup>1,2</sup> Such states may involve any one of the organ systems or several at one time.<sup>1,3</sup> The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifestations	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure  
Body Temperature Variations  
Changing pulse rate  
Deviations in B. M. R.  
Exaggerated Cold Pressure Reflex  
Oculo-Cardiac Reflex Abnormalities  
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy\*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

\*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives.<sup>8,9,10.</sup>

1. Ebaugh, F.: Postgrad. Med. 4: 208, 1948. 2. Wilbur, D.: J.A.M.A. 141: 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. 42: 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. 27: 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. 107: 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. 58: 251, 1948.

*Sandoz  
Pharmaceuticals*

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, NEW YORK



## Growth Rates AND IMPROVED NUTRITION

**A**CCORDING to an eminent authority,<sup>1</sup> increased growth rates of children are largely attributable to improved nutrition; also, "much evidence exists that current diets are often unsatisfactory." The nutrients most commonly deficient in diets of children are protein, calcium, thiamine, riboflavin, and ascorbic acid.

Ovaltine in milk—a palatable food supplement, readily accepted by children and easily digested—presents an excellent means of helping to bring even grossly deficient diets to optimal nutritional levels. It provides a wealth of biologically

adequate protein, easily emulsified fat, readily utilized carbohydrate, and essential vitamins and minerals. The addition of three servings daily to the child's diet, either at mealtime or between meals, assures nutrient intake in keeping with the dietary allowances of the National Research Council—an essential for promoting optimal growth rate.

The nutrient contribution of three servings of Ovaltine in milk is defined in the appended table.

1. Jeans, P. C.: Feeding of Healthy Infants and Children, J.A.M.A. 142:806 (Mar. 18) 1950.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

### Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,\* provide:

PROTEIN . . . . .	32 Gm.	VITAMIN A . . . . .	3000 I.U.
FAT . . . . .	32 Gm.	VITAMIN B <sub>1</sub> . . . . .	1.16 mg.
CARBOHYDRATE . . . . .	65 Gm.	RIBOFLAVIN . . . . .	2.0 mg.
CALCIUM . . . . .	1.12 Gm.	NIACIN . . . . .	6.8 mg.
PHOSPHORUS . . . . .	.094 Gm.	VITAMIN C . . . . .	30.0 mg.
IRON . . . . .	12 mg.	VITAMIN D . . . . .	417 I.U.
COPPER . . . . .	0.5 mg.	CALORIES . . . . .	676

\*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



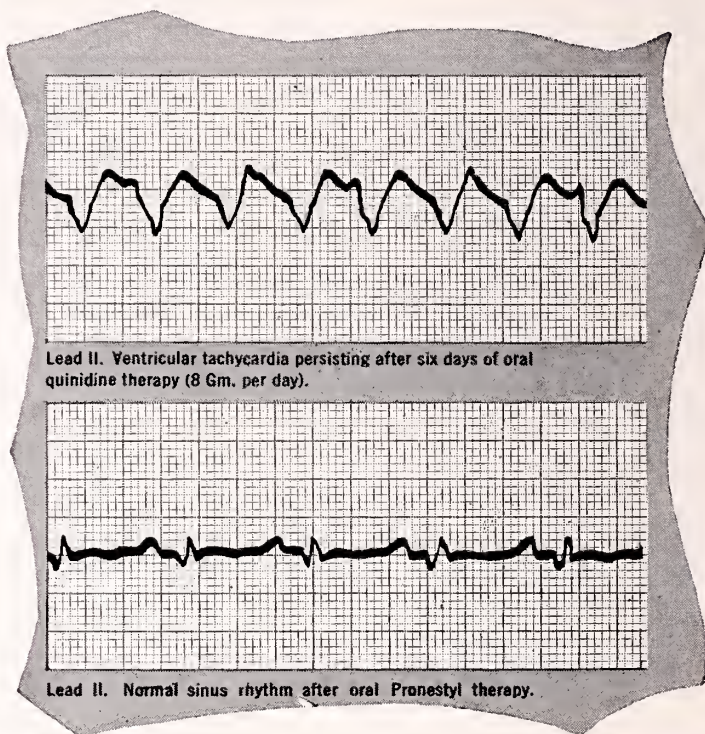


a new drug . . .

*for the treatment of ventricular arrhythmias*

## PRONESTYL *Hydrochloride*

*Squibb Procaine Amide Hydrochloride*



Oral administration of Pronestyl is indicated in ventricular tachycardia and runs of ventricular extrasystoles. Intravenous administration is sometimes used in ventricular tachycardia and to correct ventricular arrhythmias during anesthesia. For detailed information on dosage and administration, write for literature or ask your Squibb Professional Service Representative.

PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.  
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

**SQUIBB** MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.



As it has for sixty-five years, Pet Milk Company will continue to look for new ways to improve its product . . . and contribute to the nutritional welfare of the nation—especially the nation's babies. Constant research is one of many reasons why the medical profession can be assured that *when better evaporated milk is made*, Pet Milk Company will make it!

Sixty-five years ago, the first completely safe milk for babies—evaporated milk—was developed by Pet Milk Company. The new process destroyed the germs of disease which often made cows' milk a dangerous food for babies.

At the same time, Pet Evaporated Milk proved to be more easily digested than other forms of milk. Heat sterilization so changed the nature of the protein that it became soft and friable, resembling human milk in digestibility.

Then, Pet Milk was homogenized to distribute its butterfat evenly. Every drop was made uniformly rich in *all* the food values of milk.

When research proved that addition of vitamin D to milk would prevent rickets and promote optimal growth, Pet Milk was fortified with the recommended level of 400 units of vitamin D to the quart.

Later, when pure crystalline vitamin D<sub>3</sub> was developed Pet Milk was the *first* to use this improved form of vitamin D for the fortification of milk.



**Favored Form  
of Milk for  
Infant Formula**

**PET MILK COMPANY, 1424-A Arcade Building, St. Louis 1, Mo.**



OFTEN THE BUSY PHYSICIAN  
DIALS OUR NUMBER THINKING  
HE IS CALLING THE HOSPITAL

***DON'T FORGET DOCTOR,  
WE DELIVER TOO!***



**McARTHUR & SUMMERS**  
**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONE  
7-8411

# HAWAII MEDICAL JOURNAL

## and INTER-ISLAND NURSES' BULLETIN

Volume 11  
Number 1  
SEPTEMBER-OCTOBER, 1951  
\$2.00 per year  
35c per copy

Published Bi-Monthly by  
THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

### Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

### THE HAWAII TERRITORIAL MEDICAL ASSOCIATION 1951-1952

#### OFFICERS

HARRY L. ARNOLD, JR., Honolulu.....	President
R. J. MCARTHUR, Wailuku, Maui.....	President-Elect
T. DAVID WOO, Pepekeo.....	Vice-President from Hawaii County
JOHN W. DEVEREUX, Honolulu.....	Vice-President from Honolulu County
K. K. FUJII, Kapaa.....	Vice-President from Kauai County
E. T. SHIMOKAWA, Lahaina.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

#### COMMITTEE CHAIRMEN

GROVER A. BATTEN.....	Cancer Committee
TELL NELSON.....	Health Education Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	HAWAII MEDICAL JOURNAL
F. D. NANCE.....	By-Laws Committee
JOHN W. DEVEREUX.....	Advisory Board for Woman's Auxiliary
MORTON E. BERK.....	Diabetes Committee
ISAAC A. KAWASAKI.....	Public Service Committee
VERNE C. WAITE.....	Post-Graduate Committee
SAMUEL YEE.....	Legislative Committee

#### OFFICERS — COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....T. David Woo, Pepekeo	John W. Devereux	K. K. Fujii, Kapaa	Edw. T. Shimokawa, Lahaina
<i>Vice-President</i> .....S. Kasamoto, Hilo	Wm. M. Walsh	Keith Kuhlman, Koloa	John A. Burden, Paia
<i>Secretary</i> .....Francis Wong, Hilo	Wm. S. Ito	C. H. Ishii, Lihue	Edward Kushi, Wailuku
<i>Treasurer</i> .....Richard Hata, Hilo	C. M. Burgess	C. H. Ishii, Lihue	Edward Kushi, Wailuku

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1951, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.



## A Firm Foundation for a Sound Future

The first few months of life are of critical importance in building a healthy foundation for the infant. It is during this period that the demands for protein to create new tissue are greatest. And it is at this time that infants must have a food which supplies, in addition to adequate protein, other elements needed for sound growth. DRYCO feedings (with added carbohydrate) closely approximate the nutritional and digestive characteristics of human milk.

The DRYCO formula, in addition to a high-protein content, offers a reduced fat level. With added carbohydrate, DRYCO feedings assure sufficient caloric intake for normal requirements, while at the same time minimizing digestive disturbances.

Additional advantages of DRYCO are adequate vitamin and mineral potencies, moderate carbohydrate to provide formula flexibility, uniformity and bacteriological safety, as well as ease of preparation for the mother.



**VITAMIN  
FORTIFIED**

# DRYCO

*Detailed professional data, together with feeding tables may be obtained simply by writing to:*  
**THE BORDEN COMPANY, Export Division**  
350 Madison Avenue, New York 17, N. Y., U. S. A.

# An Evaluation of the Zinc Sulfate Turbidity Test in Hepatobiliary Disease

ELISABETH K. ANDERSON, M.D., AND  
W. HAROLD CIVIN, M.D.  
HONOLULU



DR. ANDERSON ✓

THE LIVER function tests in routine use are based on solitary liver functions, or are of a non-specific character influenced by multiple aberrations of the constituents of the blood.

A single all-encompassing test to determine depression of hepatic functional abilities appears at present to be beyond reach of workers in the field. Therefore, investigations have been conducted concerning the alteration of specific substances in metabolism of which the liver plays a major role.

The cephalin-cholesterol flocculation and the thymol turbidity tests are based on an attempt to evaluate serum proteins in hepatic disease. Both, however, are influenced by multiple factors including globulins, albumin, and, in the case of the thymol turbidity, lipids. Regardless of this, the thymol test is simple to perform and of creditable accuracy. The cephalin-cholesterol test, however, gives inconsistent results, is time-consuming, and, except in expert hands, is of somewhat questionable accuracy.

In 1947 Kunkel described his zinc sulfate turbidity test as a procedure for testing for parenchymatous damage of the liver, based on the estimation of gamma globulin in the serum.<sup>1</sup> It is to be noted that the zinc sulfate turbidity test is primarily a test for gamma globulin and, because of this, only indirectly a gauge of hepatic status. It is only when other causes for increased amounts of gamma globulin (of which antibodies are a great proportion) can be ruled out, that the test indicates liver damage. The liver appears to play an important role in the metabolic activities of gamma globulin.

The present paper is a result of the attempt to evaluate this test at The Queen's Hospital as a companion to the thymol turbidity test.

## Material and Method

The MacLagan thymol turbidity test was performed according to the accepted procedure except that the turbidity was read after 45 minutes on the Sheard-Sanford photometer. According to the results of Fennel<sup>2</sup>, six units were established as the upper limit of normal.

The zinc sulfate turbidity test (herein sometimes referred to as the Kunkel test) was performed as follows: To 3 cc. of reagent\*, 0.5 cc. of serum was added. The mixture was allowed to stand for 30 minutes and was then read in the Sheard-Sanford (Cenco) photometer. Values up to 10 were established as normal.

One hundred and six individuals were picked at random, and at least one Kunkel and one thymol procedure were run on each case. Many had several tests run. The patients consisted of 51 blood donors, 15 student nurses, and 40 hospital patients.

## Results

Of 51 supposedly healthy blood donors, 49 had normal Kunkel and thymol determinations. Two donors showed abnormal results in both tests. On one, no additional blood for repeat tests was available. In the case of the other donor, over a period of two weeks, the thymol turbidity became normal and the Kunkel was dropping toward normal.†

In 4 of the 15 students, both the thymol and Kunkel were normal. In the other 11, the Kunkel was elevated and the thymol was normal. It was learned that all the nurses had had inoculations against typhoid and tetanus one day previously. The Kunkels were repeated several times and in all eleven the values were normal by the following month.

Forty hospitalized patients were examined. In 22 of them, both the Kunkel and thymol tests showed normal levels. In 10 other patients, both the thymol and Kunkel results were abnormal

<sup>2</sup> Fennel, E. A.: The Clinic, Honolulu; personal communication to the authors.

\* reagent:  $\text{ZnSO}_4 \cdot 7\text{H}_2\text{O}$ —24 mgm.  
sodium barbiturate—210 mgm.  
barbituric acid—280 mgm.  
distilled water ad 1000 cc.

† The authors wish to assure the reader that these abnormal tests on blood donors are not indicative of disease. A review of 100,000 donations in 9½ years reveals 7 cases which might be acceptable as homologous serum hepatitis. As will be stressed later in the article, the doctor's evaluation of the general clinical picture is still the most important factor in diagnosis. All other tests and/or check-ups on the donors with abnormal values showed normal results.



and nine of these had proven, or very probable liver disease. Another patient had acute pelvic inflammatory disease and the antibody response could account for the elevated zinc sulfate turbidity, but the reason for the elevated thymol result is still uncertain.

In 6 cases, the thymol test showed normal levels and the zinc sulfate turbidity test showed elevated levels. In one of these cases, the patient expired and an autopsy revealed a hepatitis. In another case, a repeat of the tests revealed normal thymol turbidity and Kunkel values. A third case showed abnormal BSP retention, elevated Kunkel and normal thymol values. One case had a pituitary adenoma, a positive STS, and spinal fluid findings of a 683 mgm. protein per 100 cc. and 57 lymphocytes. The sixth case was a known leprosy patient, and Fennel has emphasized elevated levels of gamma globulin in this condition.

In two cases the zinc sulfate tests showed normal, and the thymol elevated levels. Both of these cases may have had liver damage, but there was no clinical evidence of this.

Since the above tests were done, a case has been seen at The Queen's Hospital which showed normal levels in the thymol and elevated ones in the Kunkel test. Liver biopsy revealed a cirrhosis.

One of the cases included in the normal group was treated with ACTH. Both tests then showed elevated results, but the level of the Kunkel remained abnormal for a longer period of time.

### Discussion

The work of Kunkel has shown that the zinc sulfate turbidity test is more dependent upon a single substance than any preceding method of turbidimetric serum analysis. His work and that of Maher, Mann and Snell<sup>3</sup> have shown that with diseased hepatic parenchyma, this test often gives elevated values.

It has not been the purpose of this work to establish the unitarian aspect of this procedure, nor to establish its exact accuracy in liver disease. It has been attempted here to show that the test may be run along with the thymol turbidity estimation as a gauge of liver function. We have made no comparison with the accuracy of the test it is replacing in the armamentarium at The Queen's Hospital, the cephalin-cholesterol flocculation procedure. It is the impression of one of the authors that its accuracy and reliability are greater, although some investigators would surely disagree. Most agree, however, that the test has a high degree of reliability and certainly a greater

ease of performance and reproductibility than that of cephalin-cholesterol flocculation; furthermore, it can be read in half hour in contrast to the 48-hour cephalin-cholesterol procedure. The result shows the status of the liver at the time of performance, and not of two days previously.

Our results show a complete agreement with the thymol turbidity test in 87 of 106 cases. In eleven others an explanation of increased antibody formation after immunization would be indicated by return of the zinc sulfate turbidity level to normal within one month. The two abnormal values in donors showed an agreement of the two tests, although in one case the Kunkel level had not yet reached normal at the time of the last test, and strictly speaking, this result might be considered as a discrepancy.

In two cases abnormal thymol and normal Kunkel results were seen. These patients might have had liver damage. This is only presumptive.

The six cases which had elevated Kunkel and normal thymol results included cases of hepatitis, infectious mononucleosis, and leprosy. The second condition is often associated with liver damage and the third with an elevated level of gamma globulin. A fourth case showed an agreement of the BSP test with the Kunkel value.

In all, there are two cases in which unexplained elevated Kunkel and normal thymol results were present and two in which the reverse was true. Thus, at the most, four cases showed the Kunkel test differing inexplicably from the thymol turbidity. In one of these a positive STS could account for an elevated Kunkel through the medium of altered protein (globulin) and in another a recheck Kunkel test showed a normal result. Thus, in the strictest interpretation, only 2 of 106 cases showed any unexplained deviation. This is a good laboratory correlation for liver function tests. Furthermore, in both cases wherein the two tests were grossly different and liver examination was performed, the necropsy in one and liver biopsy in the other vindicated the Kunkel procedure.

Also, it has been noted that the elevation of the level in the Kunkel test in cases wherein it disagreed with a normal thymol value has been only one or two points, whereas in proved cases of liver damage, the elevation is much higher.

If the thymol and Kunkel tests are so closely comparable, why use them together? For this, there is both a theoretical and a practical reason. The theoretical one concerns the fact that the two tests are based on different factors and the Kunkel is influenced chiefly by one element. The practical consideration concerns the fact that in the hands

<sup>3</sup> Maher, N. T., Mann, F. D., Snell, A. M.; Estimation of Serum Colloids in Hepatobiliary Disease, *Gastroenterology* 12:394 (March) 1949.

of Kunkel, Mann et al., Fennel and ourselves it has shown reliability. All the above named have felt the cephalin-cholesterol test, which in many places is run along with the thymol turbidity estimation, presents technical difficulties as well as temporal disadvantages.

We have found that if known reasons for elevated levels of gamma globulins (antibodies), such as infections, inoculations, etc., can be excluded, abnormal Kunkel test results often indicate liver damage. We feel that repeated tests are more valuable than single ones both in establishing parenchymatous liver damage and in estimating degree of improvement. This is particularly true when the thymol and zinc sulfate tests are run concomitantly. In the final analysis, the clinical evaluation of the patient must determine the status of the liver, but the thymol turbidity and Kunkel tests are tools in establishing this.

### Summary

One hundred six cases have been studied with simultaneous Kunkel and thymol turbidity tests; 75 showed normal results in both tests and ten more showed abnormal results with both tests. In only two or four cases (depending on the strictness of the comparison) did the results inexplicably differ. It is felt then that the two tests are of value as companion studies for integrity of the parenchyma of the liver and that a positive result in both can be considered as suggestive of hepatic damage if other things which cause an elevated level of globulins in the blood can be ruled out. Furthermore, the reliability, ease and reproducibility of the tests make them more desirable in evaluating liver function than more complicated ones.

The normal value for the zinc sulfate turbidity at The Queen's Hospital is under 10 units and for the thymol turbidity is under 6 units.

## Antidotes for Destruction

F. J. HALFORD, M.D.  
HONOLULU

**L**OSSES CAUSED by unsatisfactory and unsafe conditions, both in industry and outside, create a tremendous extravagance which the public must pay for. During the last generation industry has come to this realization and, along with it, has discovered that the expense of health and safety services is a good investment and can actually pay handsome dividends.



DR. HALFORD

The results of safety engineering in the last two or three decades have been outstanding, but it now appears that we have reached a leveling-out on our improvement curve. If we were to take figures from the National Safety Council for the past ten years, they would show that the curve representing the trend in accidents as a result of unsafe practices has pretty much flattened out into a straight line.

There is, however, a factor in many safety programs that has been sadly neglected, namely, the human equation. Today safety engineers who years ago applied the principles of engineering to safe methods, safe handling of materials and environment, now realize that the greatest factor, namely the human equation, must be given serious attention.

In considering the human factor, it is imperative to recognize the fact that this problem cannot be treated properly without the application of the techniques of modern industrial medicine.

The importance of this can soon be appreciated when it is realized that in spite of this coordination American industrial workers still lose an average of over nine days each year from accidents and occupational diseases alone! This means losses in spoilage and employee replacement, and large production losses running into staggering sums. Merely from the viewpoint of economics over 18,000 people per year are killed in industry and over 1,800,000 are injured, with a direct cost in deaths and injuries of over \$740,000,000. It is estimated that our economic losses from occupational diseases run at least to \$10,000,000. The physical suffering and mental anguish which all this involves can never be measured in dollars and



cents. Aside from monetary losses, the employer suffers other losses such as destruction of morale and good will, and loss of prestige, character, and reputation.

A review of the sources of accidents is certainly in order. If we know where the accidents are occurring, we can take proper steps for their understanding and control. For instance, we know that in the over-all industrial scene 30% of our employees are productive of 80% of all time lost as the result of accidents. And, what is even more astounding, on many identical jobs, 10% of the employees will produce 75% of the accidents. These people are peculiar and apart from the others. They are the ones who suffer the most—whose lives and limbs are most often sacrificed, whose homes and families are broken and torn by disability, death and insecurity, the result of accidents. It is on this group that injury wrecks its shocking and horrible vengeance, to an extent far greater than cancer. It is this group which needs our attention and our help—the accident prone!

The members of the "accident prone" group are these: (1) Those who have mental and physical defects and are employed without regard for them. (2) Those possessed of insufficient skill or knowledge—including new workers with inadequate or incomplete training. (3) Those who have the so-called "improper attitudes."

Who have the so-called "improper attitudes"? Here we find most of the 10% who will produce 75% of accidents on identical jobs and most of the 30% of those who lose 80% of the time lost as the result of accidents. In this group we discover:

The careless worker, the one who does not hesitate to take chances. He gets thrill satisfaction out of his carelessness.

The inattentive worker, the one who does not pay attention to the job at hand but who sits reading a newspaper, comic book; gazing out of the windows; unconscious of what is going on near him at the moment.

The rugged individualist, who does it his own way. He is known to all of us. The practical joker, with whom we are all familiar. He is known to most of those about him. He needs to be "corrected" quickly and have his personal responsibility in the safety program made clear.

The unhappy worker, the one plagued by private worries and cares, such as illness at home, disturbing home and family situations, and financial problems. He is ordinarily easily identifiable if the people about him are sympathetic, con-

scientious and alert. It takes so little time to be solicitous.

The worker who is disgruntled or dissatisfied is perhaps our greatest concern. The ease with which people become malcontent is emphasized by polls which indicate that about 55% of people are dissatisfied with their jobs or work. The disgruntled are thought of as rebellious, resentful, and jealous of supervision; resistant to being taught anything, including safety. Dissatisfaction may partially spring from the feeling that the worker is an inadequately paid individual, that he works too hard, or that the company is not genuinely concerned with him as an individual.

Psychologists and psychiatrists tell us that the individual needs a sense of belonging, that he is wanted, that he needs a feeling of achievement—that what he is doing is necessary. Satisfaction with work relationships and conditions will lead to contentment, security and happiness on the job. The fewer people you have who are unhappy, disgruntled and dissatisfied, the fewer you will have who are preoccupied by attitudes and things other than their work. By preoccupation I mean engrossed, lost in thought—already occupied so that their job is at the moment out of their minds. It is in that same moment that their fingers so often leave their hands; their eyesight, their eyes; their lives, their bodies.

Members of the accident prone group will frequently display one or more of a number of easily recognizable traits. Usually all one needs to discover these defects is a genuine interest in people, a friendly, kindly attitude and the taking of enough time to make inquiry in a genuine effort to be of help. A few of the characteristics that we should all be able to recognize are (1) poor attendance records; (2) habitual use of alcohol; (3) eccentricity; (4) over-aggressiveness; (5) oversensitiveness; (6) over-irritability under stress; (7) feeling of insecurity; (8) feeling of inferiority.

If we look closely we will find that these people are the ones who are most frequently emotionally upset. We should give them a large part of our attention, training and supervision because it has been truly said that no one who is emotionally upset should be working with moving machinery any more than if he were intoxicated.

So much for safety. Now let us consider the value of health service in industry.

The importance of the individual worker in our industrial scheme seems almost too obvious to call for any amplification. However, it is a fact that the most elaborate and expensively built equipment still requires people to run it. In order to get efficiency out of complicated machines, it

is imperative to have efficiency from the men and women operating them. It is a costly procedure to trust the working of our modern machines to people who are physically and mentally unfit for the job.

Once the worker has been placed on a job that he or she is physically and mentally qualified to fill, it is essential to maintain a continuous high standard of efficiency to follow and check up on the matter of health. This attention means not only with respect to organic disease processes, but also interest in the mental health of the worker. Such a follow-up involves a medical department furnished with the knowledge of the job requirements, and a very comprehensive appraisal of the worker's productive capacity based on his or her physical and mental condition. The importance of proper placement cannot be over-emphasized nor can the continued interest in the health of the worker on the job be stressed too frequently.

In order for industry to do a real job on such a task it must at the outset be certain that every employee is subjected to a thorough examination by an industrial physician who is thoroughly acquainted with the environment in the plant where the worker intends to earn his livelihood. The doctor should know the type of work the worker expects to do, the hazards involved, and the quality of the supervision in the various departments, and he should understand the company's management and labor program. In addition to the individual's physical capacity, the doctor should find out how well the individual is adjusted to such an environment, and whether he can get along well not only with himself but with his fellow workers. He should know whether he is capable of receiving supervision intelligently, and have some idea if the person's capacity is limited or if he is capable of advancement through education and guidance. The importance of getting this information means a tremendous amount to industry, as management is finding out that labor is no longer easily expendable.

It is an unfortunate error to think of physical examinations only at the time of hiring. They

should be set up on a continuing basis. Re-checks should be made whenever an employee is transferred from one job to another requiring different physical and mental capacities. If there are special hazards surrounding the job, checks should be made at regular intervals. There should also be periodic health examinations set up for all permanent employees on an annual basis. As an employee works for a company down through the years he becomes more valuable to the company because of his knowledge and experience. He also presumably increases his earning power and capacity as time marches on. Unfortunately at the same time, he grows older and becomes the potential victim of a number of physical defects incident to his advancing years. However, many of these can be detected and corrected if he has a periodic physical examination.

The value of a good health program that contemplates such periodic check-ups results in a confidence on the part of the employee that he will be placed in a job commensurate with his physical capacities, and consequently he is much more apt to become a steady rather than a transient worker.

Physical and mental health, like industrial safety, is something no plant management can afford to neglect. All plants should have an organized health program which should carry with it authority and prestige and should represent the full and sincere interests of management in the health and welfare of each and every employee. The program should be set up in such a way that its decision can be made without interference from other departments in the plant. Many concerns are presently promoting a sane health program to insure high productivity and are doing everything possible to make employees realize that good health pays them individually.

Healthy workers have few accidents, they are less susceptible to infection, they do a better job and have a better will to work. This all adds up to dollars and cents for employee and employer alike, because fewer days are lost from industrial accidents or disease.



# Incidence of Dental Caries Among School Children in Hawaii

ROBERT J. FANNING, D.D.S.

MAJOR, D.C., U.S.A.

HONOLULU

IT SEEMS that a promising approach to studying the incidence of dental caries in a community is through comparative studies of racial groups living under comparable climatic conditions. Hawaii offers an unusual opportunity for a study of this kind.

Moreover, there is a definite need of some means of measuring the progress (or lack of it) in public health dentistry in the Hawaiian Islands. Although studies have been made in a few areas in Hawaii, there exist no published data on dental conditions among the school children in Hawaii that cover all races in all areas of the islands. There are no compilations to indicate whether the teeth of school children in Hawaii are now better or worse than they were 10 or 20 years ago.



DR. FANNING

TABLE 1.—Population Figures, Jan. 1, 1950

RACE	NUMBER	PERCENT
ALL RACES .....	527,473	100.0
Hawaiian .....	10,500	2.0
Part Hawaiian .....	74,941	14.2
Puerto Rican .....	10,182	1.9
Caucasian .....	157,115	29.8
Chinese .....	31,173	5.9
Japanese .....	181,198	34.4
Korean .....	7,415	1.4
Filipino .....	53,036	10.0
All others .....	1,913	0.4

Many national and racial groups are residents in the islands (Table 1) and live in close proximity yet to a large extent maintain many of their own customs and food habits. The present-day residents of the islands have definitely adopted the continental United States' mode of living, the extent to which they have done so depending a great deal upon their financial condition.

## Materials and Methods

This report is based on data obtained from a survey of the dental record cards prepared by the Dental Hygiene Division of the Department of Public Instruction of the Territory of Hawaii for the school year 1940-50.

Dental record cards for 5,529 subjects were selected from the total number of cards for the ages of 6, 8, 10, 12, 14 and 16 years. Subjects in each group were examined by trained dental hygienists of the Dental Hygiene Division of the Department of Public Instruction using mouth mirror and explorer in a good natural light. These hygienists have had sufficient experience in performing these examinations to assure a high degree of uniformity in standards and methods.

It is estimated that the sample examined constituted about one-seventh of the whole school population of the Hawaiian Islands.

The presence and condition of deciduous as well as permanent teeth were recorded for this survey. Even in the groups of 12, 14 and 15 years of age, deciduous teeth were included in the counts.

The DMF index number of decayed teeth (D), missing (M), and filled (F) has been used to measure the caries experience. Although this method may not yield as detailed information as the A.C.F. (average caries figure) method,<sup>1</sup> yet it has been shown to be as useful and statistically sound for static surveys of this kind as any other method.<sup>3</sup> Moreover, because of its simplicity and more general use, it permits comparison with surveys elsewhere.<sup>4</sup>

## Findings and Discussion

Table 2A and B gives the detailed DMF findings for deciduous and permanent teeth for both males and females in the six age groups between the ages of 6 and 16 years. In the 6-10 age group, male and female, the decayed deciduous teeth con-

<sup>1</sup> Day, C. D. Marshall, and Sedwick, H. J.: Studies on the Incidence of Dental Caries, D. Cosmos 77:442 (May) 1925. Day<sup>2</sup>.

<sup>2</sup> Day, C. D. Marshall, and Sedwick, H. J.: The Fat Soluble Vitamins and Dental Caries in Children, J. Nutrition 8:309 (Sept.) 1934.

<sup>3</sup> Jackson, D.: An Evaluation of Two Methods of Caries Degree Estimation, British D. J. 85:79 (Aug.) 1948.

<sup>4</sup> Knutson, J. W., and Klein, H.: Studies on Dental Caries. IV. Tooth Mortality in Elementary School Children, Pub. Health Rep. 53:1021 (June) 1938, Blackerby,<sup>5</sup> Hadjmarkas, et al.,<sup>6</sup> Shourie, et al.,<sup>7</sup> Marshall-Day.<sup>8</sup>

<sup>5</sup> Blackerby, P. E., Jr.: Intrastate Geographic Variation in Dental Caries Rates, J.A.D.A. 30:1241 (Aug.) 1943.

<sup>6</sup> Hadjmarkas, D. M., Storvick, C. A., and Sullivan, J. H.: Dental Caries Experience in the State of Oregon, State Tech. Bull. 19, Agric. Expt. Stat., School of Home Economics. Oregon State College, Corvallis, Oregon (May) 1950.

<sup>7</sup> Shourie, K. L., Hein, J. W., Leung, S. W., Simmons, N. S., and Marshall-Day, C. D.: A Dental Survey of Puerto Rican Children, Unpublished Report of the University of Rochester School of Medicine & Dentistry, Division of Dental Research, Rochester, New York, 1948.

<sup>8</sup> Shourie, K. L., and Day, C. D. Marshall: Dental Experience in the Virgin Islands, J.A.D.A. 40:315 (March) 1950.

stitute about 3/4 of the total DMF figure, while the decayed permanent teeth make up about half of the total DMF figure. The greatest number of missing deciduous teeth occurred at age 10 in both males and females. The number of filled teeth constitutes a small proportion of the total DMF figure in the deciduous teeth, but approximately half of the total in the permanent teeth.

Table 3 gives the mean number of DMF teeth per subject in the various age groups. The number of DMF teeth is high at the age of six years in both the males and females. In the males there

in the deciduous dentition. The high figures for the 12-16 age group show the high incidence of dental caries in the permanent teeth.

There are reports in the literature<sup>9</sup> showing that girls have higher dental caries experience rates than boys of the same chronological age. This is also demonstrated in Table 3. It is evident from this table that in all age groups the dental caries experience of women was higher than that of men. This does not mean that females are more susceptible to the disease than males. It has been shown<sup>11</sup> that this phenomenon is due to the fact

TABLE 2A.—General Findings: DMF Deciduous and Permanent Teeth of All Races (Males Only).

AGE GROUP	NO. OF SUBJECTS	TEETH PRESENT		DECIDUOUS					PERMANENT				
		Deciduous	Permanent	D	M	F	DF	DMF	D	M	F	DF	DMF
6	828	14,870	3,355	6,081	660	1,889	122	8,752	384	3	232	9	628
8	775	9,014	9,054	4,678	481	1,644	122	6,925	1,156	21	1,126	103	2,406
10	624	4,595	9,783	2,694	988	686	61	4,429	1,727	25	1,719	145	3,616
12	297	326	7,890	241	23	40	7	311	1,461	59	1,085	137	2,812
14	215	22	5,764	22	0	0	0	22	1,191	140	1,225	70	2,626
16	193	0	5,095	0	0	0	0	0	744	311	1,320	39	2,414
6-16	2,932	28,827	41,021	13,716	2,152	4,259	312	20,439	6,633	559	6,707	503	14,432

TABLE 2B.—General Findings: DMF Deciduous and Permanent Teeth of All Races (Females Only).

AGE GROUP	NO. OF SUBJECTS	TEETH PRESENT		DECIDUOUS					PERMANENT				
		Deciduous	Permanent	D	M	F	DF	DMF	D	M	F	DF	DMF
6	781	14,852	3,150	5,388	860	1,900	121	8,169	493	4	353	15	875
8	728	8,062	8,633	3,961	525	1,524	104	6,114	1,195	7	1,473	94	2,769
10	558	3,551	9,602	2,030	888	497	53	3,468	1,805	9	1,908	179	3,901
12	201	75	6,474	60	9	12	3	84	1,440	56	1,352	90	2,986
14	169	2	4,273	2	8	0	0	10	1,218	197	1,306	51	2,772
16	169	0	4,453	0	0	0	0	0	454	269	1,507	51	2,281
6-16	2,597	26,542	36,585	11,441	2,190	3,933	281	17,845	6,605	542	7,899	480	13,526

is a gradual increase until the age of 12 when a decrease occurs, at which time many newly erupted teeth are present, and then there is a sharp increase at age 14. In the females the DMF teeth is high at age six and continues to increase until at

that girls' teeth erupt earlier than boys', therefore, they are exposed longer to the factors which influence the occurrence of the disease.

The total number of subjects in all age groups was broken down into their nationality groups. Despite the small representation of some groups, a comparison was made of the mean number of DMF teeth per subject and the actual number of subjects with caries-free dentitions in all race groups. This comparison is shown in Tables 4 and 5.

Among the nationality groups examined in Hawaii in 1949-50, there was only one Hawaiian out of 129 with caries-free dentition, 11 part-Ha-

TABLE 3.—Number of DMF Teeth per Subject All Races.

AGE GROUP	NUMBER OF SUBJECTS EXAMINED			DMF TEETH PER SUBJECT*		
	Males	Females	Total	Males	Females	Combined
6	827	781	1,608	11.3	11.6	11.4
8	775	728	1,503	12.0	12.2	12.1
10	624	558	1,182	12.9	13.2	13.0
12	297	201	498	10.5	15.2	12.4
14	215	160	375	12.3	17.4	14.5
16	193	169	362	12.5	13.5	13.0
6-16	2,931	2,597	5,529	11.9	13.9	12.9

\* DMF figures include deciduous and permanent teeth.

the age of 14 it reaches its highest DMF figure (17.4 per cent). The high DMF figure shown for the 6-10 year age group is a measure of the early caries activity and the high incidence of decay

<sup>9</sup> Stoughton, A. L., and Meaker, V. T.: Sex Differences in the Prevalence of Dental Caries, Based on 12,435 Oral Examinations by Dental Personnel in Georgia, Illinois, Missouri, and Hagerstown, Md., Pub. Health Rep. 47:26, 1932. Klein et al.<sup>12</sup>  
<sup>10</sup> Klein, H., Palmer, C. E., and Knutson, J. W.: Studies on Dental Caries: I. Dental Status & Dental Needs of Elementary School Children, Pub. Health Rep. 53:751, 1938.  
<sup>11</sup> Klein, H., and Palmer, D. E.: Studies on Dental Caries: VII. Sex Differences in Dental Caries Experience of Elementary School Children, Pub. Health Rep. 53:1685, 1938.



waiians out of 914, 10 Japanese out of 2,576, 9 Filipinos out of 707, 4 Chinese out of 192, 12 Caucasians out of 113, 12 misce-genetics out of 729, and 12 part-Caucasians out of 203.

In the 6-16 age group the Japanese had the greatest incidence of dental caries, while the Caucasians had the lowest DMF rate. Most of the

therefore, probably lacking in fluorides. Nekomoto<sup>12</sup> reported that the drinking water of various areas of Oahu had a low fluorine content (0.02 to 0.2 ppm). Bryson<sup>13</sup> of the Honolulu Board of Water Supply by various methods made a number of investigations on the fluorine content of the city's water. He concluded from his investigations

TABLE 4.—Number of Subjects with Caries Free Dentition According to Age and Race.

AGE GROUP	NUMBER OF SUBJECTS							NUMBER WITH CARIES FREE DENTITION								
	H	P-H	JAP.	FIL.	CHIN.	CAUC.	MISCE-GENETIC	OC.	H	P-H	JAP.	FIL.	CHIN.	CAUC.	MISCE-GENETIC	OC.
6	20	217	810	195	47	54	203	62	1	3	6	3	1	8	7	11
8	35	212	755	180	47	33	195	46	0	5	0	3	2	2	1	0
10	32	260	465	174	39	17	163	32	0	2	1	0	1	1	0	0
12	12	79	206	97	8	8	75	13	0	1	1	3	0	1	4	1
14	6	48	230	36	17	0	37	10	0	0	1	0	0	0	0	0
16	24	98	110	25	34	1	56	40	0	0	1	0	0	0	0	0
6-16	129	914	2,576	707	192	113	729	203	1	11	10	9	4	12	12	12

All Ages

TABLE 5.—Incidence of Caries or Lost Teeth According to Age and Race.

AGE GROUP	NUMBER DMF PER SUBJECT							
	H	P-H	JAP.	FIL.	CHIN.	CAUC.	MISCE-GENETIC	OC.
6	11.2	10.4	12.5	9.8	16.5	9.8	10.4	7.5
8	12.1	10.8	13.2	11.2	12.8	11.1	10.9	8.6
10	11.8	8.1	15.9	13.8	12.1	9.6	13.5	10.0
12	9.6	11.2	15.2	9.8	10.7	7.1	11.8	6.8
14	13.5	14.0	15.3	13.5	11.5	0	12.5	15.0
16	12.4	12.4	15.5	11.3	13.6	10.0	12.1	11.5
6-16	11.7	11.2	14.6	11.5	12.9	9.5	11.8	9.9

Caucasians examined were born here in the islands.

Comparative caries incidence figures for Hawaii with population groups elsewhere are set forth in Table 6. The number of DMF teeth per child is

TABLE 6.—Comparative Caries Incidence in Population Groups.

AGE IN YEARS	DMF PER CHILD			
	U.S.A.	Puerto Rico <sup>7</sup>	Virgin Islands <sup>8</sup>	Hawaiian Islands
6	1.8 <sup>4</sup>	5.3	8.3	11.4
8	5.6 <sup>5</sup>	9.1	7.9	12.1
10	3.7 <sup>5</sup>	6.9	5.7	13.0
12	3.0 <sup>5</sup>	6.4	6.2	12.4
14	10.4 <sup>6</sup>	7.2	8.5	14.5
16	12.9 <sup>6</sup>	8.4	8.7	13.0

substantially higher in the Hawaiian Islands in all age groups than in comparable groups in the United States, Puerto Rico, and the Virgin Islands.

Although it is not within the scope of this paper to discuss the causes of this high incidence of dental caries in the school children, it is thought that the drinking water which is obtained in some areas from rain collected in catchment areas, is

<sup>12</sup> Nekomoto, R. S.: Monograph. Univ. of Hawaii Library, 1945.

<sup>13</sup> Bryson, L. T.: Analytic Methods for Determining Fluorides in Water Supplies. Unpublished report of Honolulu Board of Water Supply (April) 1948.

that the fluorine content of Honolulu water is even lower than that found by Nekomoto and is actually in the range of 0.05 to 0.10 ppm.

Other factors have not been studied, although the high consumption of sweetened beverages in this warm climate cannot be disregarded.

### Summary

A survey based on the dental record cards of the Dental Hygiene Division of the Department of Public Instruction has been made for the islands of Maui, Kauai, Hawaii and Oahu in the Hawaiian Islands group. The average DMF figures, 11.4 at age six, 12.1 at age 8, 13.0 at age 10, indicates a high degree of caries activity in the deciduous dentition. The average DMF figure ranged from (12.2) in the 12 year group to (14.5) at 14 years to (13.0) at 16 years. The number of DMF teeth per subject is substantially higher than has been reported for comparable age groups (6-16 years) in other areas of the world. From a comparison of the number of caries-free dentitions and the number of DMF teeth per subject it seems evident that there is no racial influence under environmental conditions in the Hawaiian Islands.

### Acknowledgments

Records utilized for this survey and the data presented in this paper were obtained through the courtesy of the Dental Hygiene Division of the Territorial Department of Public Instruction.

Most of the records for the 14 and 16 year olds were obtained from a high school in Honolulu.

Appreciation is expressed to Carey D. Miller, Professor of Foods and Nutrition, University of Hawaii, under whose guidance this work was accomplished.

# Hawaii MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D.	Editor
MRS. EDITH C. BENNETT	Managing Editor
HASTINGS H. WALKER, M.D.	Advisory Board
HOMER IZUMI, M.D.	Advisory Board
PETE OKUMOTO, M.D.	Associate Editor, Hawaii
EDWARD S. KUSHI, M.D.	Associate Editor, Kauai
C. H. ISHII, M.D.	Associate Editor, Maui

## [ EDITORIALS ]

### FIFTH PAN-PACIFIC SURGICAL CONGRESS — NOVEMBER 12 - 16, 1951

Registration for the Fifth Congress will begin November 7, and the scientific program on November 12. Top flight surgeons from the Pacific area countries will present papers. Doctors are expected to come from China, Japan, New Zealand, Australia, Alaska, Canada, South America and the mainland, U. S.

Further information concerning the meeting may be obtained from the office of the Pan-Pacific Surgical Association, Suite 7, Young Hotel Building, telephone 65027.

### LEAHI HOSPITAL, 1901 - 1951

Leahi Hospital for Tuberculosis passed its fiftieth anniversary last August and opened its newest, finest and largest building, the one-and-three-quarter-million-dollar Alexander Young Building, named for the first President of its Board of Trustees. The same day marked the twenty-seventh anniversary of Dr. Hastings H. Walker's association with the institution.

Medical distinction is Leahi's, in full measure. The standards of medical and surgical care in this institution have been a source of pride to Hawaii for many years now; they are second to none in the world. One of the most important recent advances in chest surgery—dermal grafts for bronchial stenosis—was made by a member of Leahi's staff, Dr. Paul Gebauer, and first reported in the HAWAII MEDICAL JOURNAL in July 1949. It has become world famous; indeed, a recent article in the *Revue de la Tuberculose* is entitled "Reconstruction Plastique de la Bronche pour Sténose Tuberculeuse (Operation de Gebauer)"!

Perhaps even more significant, however, is the socio-political distinction achieved by this remark-

able institution; certainly it is rare, and perhaps it is unique, that a fully tax-supported public institution should be operated entirely by a private, volunteer, Board of Trustees—private citizens of outstanding ability, probity and distinction in their own fields, whose services would be prohibitively expensive were they to be obtained through the usual procedure of employing them at a salary. Leahi is so operated. It is a private institution run with public funds. It is independent of politics, independent of government controls (except for those which would affect any private hospital as well), and altogether uninfected by the virus of what Governor Dewey once called the "dead level of governmental mediocrity."

Part of this shining success—a large part of it—must be attributed to the individuals at the helm. But part of it may be attributed to this unusual and highly successful admixture of government funds and private-enterprise administration. Perhaps this points the way to a solution of some other community problems besides the treatment of tuberculosis.

H.L.A.



### REHABILITATION: A GROWING PROBLEM

As acute illnesses occupy less and less of the time of both physician and patient, chronic degenerative and disabling illnesses are coming to occupy more and more. Interest in chronic heart disease, cancer, geriatrics, and so on is increasing steadily. So is interest in chronic disability in general, and in physical medicine and rehabilitation in particular.

Rehabilitation is a vastly more complex subject than the physical medicine or physiotherapy of our medical school days. It deals with such diverse problems as arthritis, tuberculosis, heart disease, a spate of geriatric disorders, hemiplegia, paraplegia, traumatic diseases, amputations, poliomyelitis, congenital anomalies, cerebral palsy, speech disturbances, blindness, epilepsy, and numerous psychiatric and neurologic diseases.

Coordinated programs of rehabilitation aimed at restoring the functions and at least part of the earning power of individuals thus variously handicapped are developing in many mainland cities. Community rehabilitation centers, under medical direction, are providing integrated services in physical therapy, occupational therapy, speech training, social and psychiatric counseling, vocational testing, and vocational training.

These centers are like highly specialized hospital out-patient departments, to which patients are referred by their physicians for these special services.

A special committee of the Oahu Health Council, with medical representation, has already undertaken to explore the situation here in Hawaii with reference to needs, available facilities and services; the extent to which existing agencies are able to integrate their activities with one another; and the way in which a rehabilitation center, if it appears that one is needed here, can best be established and financed. We will all be keenly interested in the results of their investigation.

### THE MENACE OF EPIDEMIC DIARRHEA

Epidemics of diarrhea in newborn nurseries of hospitals are always serious and often cause considerable morbidity with some mortality. Such an epidemic recently occurred in a hospital in the Territory. The hospital immediately sought advice from many available sources, principally the Board of Health through its Departments of Maternal and Child Health, Laboratory, Communicable Diseases, and others. The problem was recognized and studied from its many angles and immediate steps were taken to meet the problem and prevent

its recurrence. There was only one newborn death, though nearly all the other babies in the nursery at the time were ill to some degree, some seriously.

Right now every general hospital in the Territory could well study its entire newborn nursery routine with this ever present danger in mind, and make certain that the advice of the best-authorities in this field is followed.

### A NEW MEDICAL CARE PROGRAM

By the enactment of Act 129, creating the Division of Hospitals and Medical Care in the Department of Health and providing for the medical care of the indigent and the medically indigent, the Legislature of the Territory of Hawaii has now centralized the medical care program under one territorial government agency. This act provides for a territorial advisory commission and county advisory health committees, members to be appointed by the Governor and the mayor or chairmen of the county governments, respectively. The medical profession has representation in both groups. Active participation in the policy making and planning and supervision of the medical care program at county and territorial levels is expected of these men. The medical profession expects the physicians on the advisory committees to keep the local component societies continually informed of this program.

It should be emphasized that the responsibility for developing policies lies not only with the medical men appointed to the foregoing commission and committees but with every individual physician in the Territory. Practicing physicians will be rendering services to patients coming under this program. The policies adopted by the Health Department for the care of these patients will have a far-reaching effect on other present and future medical services provided for by physicians. Every practicing physician must realize that any action on the part of individual members for monetary gain or for special interest will endanger the total medical program not only for this group but for the present system of medicine now practiced in Hawaii. Act 129 can become a very dangerous tool if not administered properly and if the medical profession allows it to expand beyond reasonable needs. The present leaders in the health department may be expected to administer realistically and practically this program in order to provide the greatest benefit and service to patients who come under the provisions of this act and within the appropriations allotted. The thoughtful participation and cooperation of every physician in Hawaii is needed.

## FEDERAL MEDICAL SERVICES

The doctors of this country are faced with a responsibility to make their voices heard in the forthcoming discussion that will result from Congressional consideration of the bills affecting federal medical services.

These bills (S. 1140 and H.R. 3305 and 3688), if enacted, would create a new Department of Health, with Cabinet status which would unify and bring under one central control the thirty-odd medical systems of the government.

There is no doubt that this unification is needed or that some plan will probably be adopted to correct it; perhaps that legislation, which follows recommendations of the bipartisan Hoover Commission, or some other method yet to be advanced.

The point is that this question of national importance should be of greater interest and concern to the doctors than to any other group. It is therefore desirable, in fact essential, that the thinking of the medical profession be explored and the opinions of its members be brought to the attention of Congress before that body acts upon any legislation.

One thing is sure. Unless the doctors make their position clear, some legislation might be engineered by lay groups which not having the doctors' point of view, might do them a disservice.

For these reasons the National Doctors Committee for Improved Federal Medical Services has been created. It is a fast-growing, nation-wide politically nonpartisan body of medical men with the welfare of their country and their profession at heart. It is not a pressure group and not a lobby.

The policies of this committee are being formulated by an advisory committee of doctors representing all branches of medicine and many parts of the country.

It may be that doctors generally are not aware of the situation that exists in the vast conglomeration of the Federal Medical Services. They may not realize the unnecessary waste of scarce medical manpower that results from the duplication of skills by five major and 30 smaller medical systems controlled by the government.

The Army, Navy, Air Corps, Veterans Administration and the Public Health Service are con-

ducting independent and competing hospital systems which are not coordinated. They compete for appropriations from Congress, for medical specialists, for nurses and for supplies. This results in vast waste of men and material and the system is costing the taxpayers \$2 billions a year.

There is no central authority or supervision over these separate systems and there is no plan for the transport of medical personnel or equipment in the event of a great emergency such as an air attack. There is no law making such coordination possible.

Some of these units, notably the Veterans Administration, build hospitals in areas where it is impossible to staff them and sometimes spot a new hospital in an area where an institution of one of the other units is being shut down.

The whole country has been made conscious of the danger of possible atomic attack. We have organized defense systems, established air raid warning signals and bomb shelters. But what is going to happen to the populations of bombed areas? An air attack would probably destroy the local hospitals and, if they were spared, would conceivably result in casualties far outnumbering the available beds and overwhelming the local physicians. There is the Red Cross, but as a voluntary organization it might lack the authority needed in such an emergency. Fine as it is, it might not, alone, be able to cope quickly with a catastrophe of the magnitude, from experiences in Japan, such a bombing would assume. It might require the full weight and authority of government hospital services.

While there are various opinions about whether or not we have an actual shortage of doctors, there is no doubt that their distribution, especially into the armed services, is having an effect in many sections.

These are matters which the committee believes doctors should take to heart, to ponder and to be able to voice their opinions when they come before the Congress for solution.

**ROBERT COLLIER PAGE, M.D.\***

\* Chairman of the National Doctors Committee for Improved Federal Medical Services, an affiliate of the Citizens Committee for the Hoover Report.



## HAWAII NSCCA SERVICES TO PHYSICIANS IN REHABILITATION OF THE HANDICAPPED

"Millie" first came to the attention of the Hawaii Chapter, National Society for Crippled Children and Adults, August 21, 1948, when she was referred to the Society's Sultan School for Handicapped Children by her family physician. The referring physician diagnosed the case as cerebral spastic paralysis, athetoid type.

The child, age 3 years, 10 months, was unable to sit without support, stand, walk, talk, feed herself, or see to her other personal needs. A subsequent psychological examination brought the clinician's report that Millie's motivation was excellent, and she was mentally alert and of average intelligence, though it was pointed out that her difficulty in motor coordination made it possible to give only scattered tests.

With the assistance and counsel of the referring physician, facilities at Sultan School were brought into play in a long range rehabilitation plan for Millie. Upon prescription of her physician, therapy was provided to enable her to develop strength, balance, and coordination for sitting, standing, and walking; to feed herself and see to her personal needs; and to learn to speak. Socialization experience was provided through guided contact with other children at the school, and consultation with the family made possible the provision of special facilities and equipment suited to the child's needs at home.

On December 7, 1949, Millie was fitted with braces recommended by a consulting orthopedist. By April, 1950, she was standing independently and was beginning to walk with crutches. Through continued occupational and speech therapy, she was also beginning to

speak and had learned to feed herself and drink out of a cup.

By June of the same year, recommendation of the physician on the case was that special emphasis be placed upon practice in walking and learning how to fall, so that the child would be able in time to ambulate without help. The object of treatment during the coming year was to prepare the child for entrance into a special classroom provided for formal education of handicapped children by the public school department.

In May of this year, Millie was able to walk the distance of the physical therapy treatment room, stand indefinitely without support, and get into and out of a chair with apparent ease. Though somewhat indistinct, her speech was understandable and showed considerable improvement when she was able to relax. A report upon psychological re-examination showed that it was believed she could enter a special class to receive formal education during the coming fall. The psychological report further recommended early planning of a special training program, as it was felt she could eventually hold a job in an industrial enterprise where visual discrimination, endurance, and a pleasing personality were needed.

This case, on record at Sultan School for Handicapped Children, is typical of many cases receiving coordinated rehabilitation services at the school since its establishment September 1, 1948. Referred by public and private agencies, the Department of Health, and private physicians, over 150 children have received similar services designed to fit them for entrance into normal schools or special classrooms for the handicapped offered in the public schools. Handicaps of these children have varied from cleft palate, speech retardation, hearing and visual defects, to poliomyelitis, cerebral palsy, and other orthopedic handicaps.

The Sultan School, located on the grounds of Kaula Children's Hospital, received its original endowment from the Sultan Foundation, an eleemosynary foundation in Honolulu. Sponsored and operated by the Hawaii Chapter, National Society for Crippled Children and Adults, it is the only therapeutic nursery school in the territory. The school is operated in accordance with medical policies recommended by a Medical Advisory Committee of five local physicians serving on a voluntary basis, and is further guided in its educational and administrative phases by a Nursery School Committee composed of local educators, professionals, businessmen, and prominent citizens in the community.

Development of facilities at Sultan School is part of a broad direct aid program for the handicapped carried on in the territory by the Hawaii NSCCA and its affiliated local units since the Society's establishment here in 1947. Other direct aid offered by the organization includes provision of orthopedic appliances, a special summer training institute for preschool hard-of-hearing and deaf children, a summer day camp, a treatment center on the island of Hawaii, recreational centers at Windward Oahu and on the island of Maui, and a speech therapy program on Kauai. All of these services are financed through the Easter Seal Campaign, conducted by the Society throughout the territory each year.



*Physical Therapy at Sultan School—Child on P. T. table receives her regular treatment, while youngster in the background goes to work in the gait trainer.*

MRS. MAPUANA MCCOMAS  
Executive Secretary  
Hawaii Chapter, NSCCA

## MEDICAL NEWS

**Progesterone**, 100 mg. daily intramuscularly, is recommended by Trunnell, et al., in the treatment of **cancer of the prostate** after castration and estrogen therapy have failed. The majority of patients will improve, a few will be made much worse. Any port in a storm.

A new testosterone derivative, **testosterone cyclopentylpropionate (TCP)** has a duration of effectiveness 2 to 4 times as great as ordinary testosterone propionate. A single injection of 50 to 300 mg. was invariably effective for 28 days or longer (measured objectively by 17-ketosteroid excretion, *not* subjectively). (Lloyd and Fredericks, *J. Clin. Endocrinol.* 11:724 [July] 1951.)

**Cation exchange resin** given orally is a convenient way to control **edema** in the nephrotic syndrome, according to Lippman (*Arch. Int. Med.* 88:9 [July] 1951). Potassium and calcium are also removed by the resin and paralysis or convulsions will occur unless these ions are given simultaneously.

Varied **dermatoses of pregnancy** were cured in 10 of 10 patients by the use of **progesterone**, 25 to 50 mg. daily. (Keaty, et al. *Arch. Derm. & Syph.* 63:675 [June] 1951.)

"**Worthless**" is the consensus of opinion of dermatologists from all sections of the country who were interviewed (by questionnaire) regarding the value of **undecylenic acid** in the treatment of **psoriasis**. (Rattner and Rodin, *J.A.M.A.* 146:1113 [July 21] 1951.)

**Sodium dehydrocholate** intravenously increased arterial blood flow through the liver and doubles survival time in hemorrhagic shock in animals. Hay and Webb suggest it **may delay onset of shock** and prove useful as a temporary measure until blood can be obtained for transfusion. (*Surgery* 29:826 [June] 1951.)

**Pentothal** given intrathecally produces complete **spinal anesthesia**, according to Morrison, et al. (*Anesthesiol.* 12:315 [May] 1951). A continuous drip of 200 to 800 mg. was adequate for most operations. Central depression, probably due to absorption of the drug, was frequent.

**Intravenous ACTH** is cheaper and more effective, according to McIntosh and Holmes (*Canad. M. J.* 65:33 [July] 1951). In a 24-hour drip, 2.5 mg. of ACTH

gives the same effect on eosinophils and 17-ketosteroid excretion as 20 mg. given intramuscularly every six hours. The optimal dose is 10 mg. in a 24-hour drip.

**Eurax** (N-ethyl-O-crotonotoluidide) cited a year ago in this column as a potent new scabicide, is also an excellent **antipruritic** agent, according to Johnson and Bringe (*Arch. Derm. & Syph.* 63:769 [June] 1951). Good results were obtained by them in 74 per cent of 121 patients.

**Regitine** (Ciba) is a new **adrenolytic**, superior to Benzodioxane in that intramuscular and oral administration is possible. Iseri, et al., describe regression of papilledema and sustained decrease of blood pressure during one month of oral therapy in a patient with a pheochromocytoma. (*Am. Heart J.* 42:129 [July] 1951.)

Best and Coe report that enteric coating does not reduce the G.I. upsets which complicate the use of khellin in the treatment of **angina pectoris**. Fewer side effects, and just as good relief of angina, was found with dioxylone phosphate ("**Paveril phosphate**") a new synthetic similar to papaverine. (*Am. J. Med. Sci.* 222:35 [July] 1951.)

**Dibuline** (Merck) (formerly called dibutaline), 40 mg. every three hours produces the same great **reduction in gastric acid**, chloride, pepsin and volume as 1 mg. (gr. 1/60) of atropine. Such a dose of atropine is intolerable, but 40 mg. of dibuline is well tolerated, according to Lorber and Shay. (*Am. J. Med. Sci.* 222:82 [July] 1951.)

**Sublingual** administration of **heparin** may prove to meet the long felt need for an anticoagulant which can be given by mouth and be effective within one hour. Litwins, et al., describe the use of wafers containing 125 mg. of sodium heparin. The pellet disintegrates rapidly in the sublingual pouch and a therapeutic level is obtained within 30 minutes and is maintained for four hours. (*Proc. Soc. Exp. Biol. & Med.* 77:325 [June] 1951.)

C. A. DOMZALSKI, JR., M.D.



# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*  
 MRS. MARTHA WEBER, *Assistant Librarian*  
 Phone 65370  
 8:00 a.m.-4:30 p.m., and 7:30 p.m.—9:30 p.m.  
 Monday through Friday  
 Closed Saturdays at noon and Sundays  
 Closed all day and evening on National holidays  
 and at noon on Territorial holidays

## Recent Acquisitions

### Allergy

Rinkel, H. J. *Food allergy*. c1951. (gift of publisher)

### Anatomy and Physiology

Smith, C. A. *The physiology of the newborn infant*.  
 2nd ed. c1951. (gift of publisher)

### Cardiology

Levine, S. A. *Clinical heart disease*. 4th ed. c1951.  
 (gift of publisher)  
 Weiss, Edward *Emotional factors in cardiovascular  
 disease*. c1951. (gift of publisher)

### Diabetes

Duncan, G. G. *Diabetes mellitus*. c1951. (gift of publisher)

### Drugs

Greenberg, L. A. *Antipyrine*. c1950. (gift of the Institute for the Study of Analgesic and Sedative Drugs)  
 Veterans Administration. *Conference on cortisone research*. c1951. (gift of Veterans Administration)

### Endocrinology

Thorn, G. W. *The diagnosis and treatment of adrenal insufficiency*. 2nd ed. c1951. (gift of publisher)

### Gynecology and Obstetrics

Farris, E. J. *Human fertility*. c1950.  
 Portnoy, Louis. *Fertility in marriage*. c1950.

### Leprosy

Memoria del V Congreso Internacional de la lepra.  
 1949. (gift of Mr. Judd)

### Medicine

Boshes, Benjamin, ed. *A review of medicine by members of the faculty, Northwestern University Medical School*. c1951. (gift of publisher)  
 Cecil, R. L., ed. *A textbook of medicine*. 8th ed. c1951. (gift of publisher)  
 Chatton, Milton. *Handbook of medical management*. 2nd ed. c1951. (gift of publisher)  
 Cutting, W. C. *Annual review of medicine*. v.2. 1951. (gift of Dr. Frazier)

### Neurology and Psychiatry

Alvarez, W. C. *The neuroses*. c1951. (gift of publisher)  
 Engel, G. L. *Fainting*. c1950. (gift of publisher)  
 Scheinker, I. M. *Medical neuropathology*. c1951. (gift of publisher)

### Nursing

McClain, M. E. *Scientific principles in nursing*. c1950. (gift of publisher)

### Orthopedics

Steindler, Arthur. *Postgraduate lectures on orthopedic diagnosis and indications*. c1951. (gift of publisher)

### Pathology

Wells, B. B. *Clinical pathology*. c1950. (gift of publisher)

### Roentgenology

Poppel, M. H. *Roentgen manifestations of pancreatic disease*. c1951. (gift of publisher)  
 Shanks, S. C. *A textbook of X-ray diagnosis*. v.1 2nd ed. c 1951. (gift of publisher)

### Surgery

DePalma, A. F. *Surgery of the shoulder*. c1950. (gift of publisher)

### Therapy

Cass, M. T. *Speech habilitation in cerebral palsy*. c1951.  
 Kendell, H. W. *Fever therapy*. c1951. (gift of publisher)

The Library will welcome from the doctors gifts of journals to which they subscribe. It will be necessary, however, that doctors who agree to donate journals do so regularly and consistently, so that current issues are available without too much delay and our files are complete. Such contributions would be a great help financially to the Library.

At the present time, we are receiving the following journals through the generosity of the doctors listed:

<i>American Journal of Clinical Pathology</i> .....	Dr. Tilden
<i>American Scientist</i> .....	Dr. Arnold, Sr.
<i>Annals of Internal Medicine</i> .....	Dr. Arnold, Sr.
<i>Archives of Ophthalmology</i> .....	Clinic
<i>Archives of Otolaryngology</i> .....	Clinic
<i>Archives of Pathology</i> .....	Clinic
<i>British Journal of Industrial Medicine</i> .....	Medical Group
<i>Bulletin of the History of Medicine</i> .....	Dr. Pleadwell
<i>Child</i> .....	Dr. Larsen
<i>Chronicle of the World Health Organization</i>	Dr. Larsen
<i>Excerpta Medica</i>	
( <i>Anatomy, anthropology, etc.</i> ).....	Medical Group
( <i>Endocrinology</i> ).....	Medical Group

(Obstetrics and Gynaecology).....	Medical Group
(Ophthalmology).....	Dr. Holmes
(Pediatrics).....	Medical Group
(Radiology).....	Dr. Buzaid
Harvard Medical Alumni Bulletin.....	Dr. Pleadwell
Industrial Medicine and Surgery.....	Dr. Patterson
Insurance Economics Survey.....	Dr. Arnold, Jr.
International Surgical Digest.....	Medical Group
Journal of Bacteriology.....	Clinic
Journal of the Bowman Gray School of Medicine.....	Dr. Patterson
Journal of Heredity.....	Dr. Hosoi
Journal of the International College of Surgeons.....	Dr. Fronk
Journal of Investigative Dermatology.....	Clinic
Military Surgeon.....	Dr. Pleadwell
Modern Concepts of Cardiovascular Disease.....	Dr. DeHay
Obstetrical and Gynecological Survey.....	Medical Group
Proceedings of the Society for Experimental Biology and Medicine.....	Dr. Sia
Proceedings of the Staff Meetings of the Clinic.....	Clinic
Psychological Abstracts.....	Dr. Weeber
Psychological Bulletin.....	Dr. Weeber
Science.....	Dr. Weeber
Scientific Monthly.....	Dr. Hosoi
Transactions of the American Academy of Ophthalmology.....	Dr. Holmes
Transactions of the American Academy of Otolaryngology.....	Dr. Pinkerton
Transactions of the Royal Society of Tropical Medicine and Hygiene.....	Dr. French
Tropical Medicine News.....	Dr. Patterson
U. S. Navy Medical News Letter.....	Dr. Pleadwell
Yale Journal of Biology and Medicine.....	Dr. Childs

The Board of Medical Examiners recently purchased a small collection of textbooks for the Library, with the purpose of supplying review material for the use of doctors preparing for their examinations. These books will bear the Gift bookplate, and be marked and shelved in the alcove off the main Reading Room. The Board furnished nine feet of shelving to accommodate the collection, and intends to add new material each year to keep it up to date. Though purchased primarily for examination minded individuals, the Board wishes to make these books available to all doctors and nurses. Following is a list of books already received in the Medical Library:

De Palma, A. F. *Surgery of the shoulder*. c1950.  
 Shepard, W. P. *Essentials of public health*. c1948.  
 Beaumont, G. E. *Recent advances in medicine*. 12th ed. 1947.  
 Edwards, H. C. *Recent advances in surgery*. 3rd ed. 1948.  
 Brain, W. R. *Recent advances in neurology and neuropsychiatry*. 5th ed. 1945.  
 Stevenson, R. S. *Recent advances in otolaryngology*. 2nd ed. 1949.  
 East, Terence *Recent advances in cardiology*. 4th ed. 1948.  
 Hadfield, Geoffrey. *Recent advances in pathology*. 5th ed. 1947.  
 Burn, J. L. *Recent advances in public health*. 1947.  
 Newton, W. H. *Recent advances in physiology*. 7th ed. 1949.  
 Heaf, Frederick. *Recent advances in respiratory tuberculosis*. 4th ed. 1948.

Hewer, C. L. *Recent advances in anaesthesia and analgesia*. 1948.  
 Cameron, A. T. *Recent advances in endocrinology*. 6th ed. 1947.  
 Dyke, S. C., ed. *Recent advances in clinical pathology*. 1947.  
 Robson, J. M. *Recent advances in sex and reproductive physiology*. 3rd ed. 1947.  
 Bourne, A. W. *Recent advances in obstetrics and gynaecology*. 7th ed. 1940.  
 Smith, Austin. *Technic of medication*. c1948.  
 Hilton, John. *Rest and pain*. New rev. ed. 1950.  
 Fulton, J. F. *Physiology of the nervous system*. 3rd ed. rev. c1949.  
 Friedberg, C. K. *Diseases of the heart*. c1949.  
 Nelson, W. E., ed. *Mitchell-Nelson textbook of pediatrics*. 5th ed. c1950.  
 Schafer, P. W. *Pathology in general surgery*. c1950.  
 Thorek, Philip. *Anatomy in surgery*. c1951.  
 Toldt, Carl. *An atlas of human anatomy*. 2 v. 2nd ed. c1928.  
 Thorner, M. W. *Psychiatry in general practice*. c1948.  
 Brock, Samuel, ed. *Injuries of the skull, brain and spinal cord*. n.d.  
 Meigs, J. V., ed. *Progress in gynecology*. v.2. c1950.  
 Rosebury, Theodor. *Peace or pestilence*. c1949.  
 Lyons, W. R. *Atlas of peripheral nerve injuries*. c1949.  
 Aggeler, P. M. *Hemorrhagic disorders*. c1949.  
 Rolnick, H. C. *The practice of urology*. 2 v. c1949.  
 Bacon, H. E. *Anus, rectum, sigmoid colon*. 3rd ed. 2 v. c1949.  
 Pick, J. F. *Surgery of repair*. 2 v. c1949.  
 Oldham, F. K. *Essentials of pharmacology*. c1947.  
 Bacon, H. E. *Essentials of proctology*. c1943.  
 Tobias, Norman. *Essentials of dermatology*. 3rd ed. c1948.  
 Goldthwait, J. E. *Essentials of body mechanics*. 4th ed. c1945.  
 Crip, L. H. *Essentials of allergy*. c1945.  
 Pritikin, R. I. *Essentials of ophthalmology*. c1950.  
 Wintrobe, M. M. *Clinical hematology*. 2nd ed. rev. c1946.  
 Archer, V. W. *The osseous system*. c1945.  
 deLorimier, A. A., ed. *The arthropathies*. 2nd ed. c1949.  
 Kerr, H. D. *The urinary tract*. c1944.  
 Rigler, L. G. *The chest*. c1946.  
 Hodges, F. J. *The gastro-intestinal tract*. c1944.  
 Young, B. R. *The skull, sinuses and mastoids*. c1948.  
 Willis, R. A. *Pathology of tumors*. 1948.  
 Titus, Paul. *Atlas of obstetric technic*. 2nd ed. c1949.  
 Wharton, L. R. *Gynecology*. 2nd ed. c1947.  
 Custer, R. P. *An atlas of the blood and bone marrow*. c1949.  
 Bancroft, F. W., ed. *Surgical treatment of the nervous system*. c1946.  
 Weiss, Edward. *Psychosomatic medicine*. 2nd ed. c1949.  
 Truex, R. C. *Detailed atlas of the head and neck*. c1948.  
 Rankin, F. W. *Cancer of the colon and rectum*. 2nd ed. c1950.  
 Ladd, W. E. *Abdominal surgery of infancy and childhood*. c1941.  
 Beckman, Harry. *Treatment in general practice*. 6th ed. c1948.  
 Todd, J. C. *Clinical diagnosis by laboratory methods*. 11th ed. c1948.  
 Noyes, A. P. *Modern clinical psychiatry*. 3rd ed. c1948.



## BOOK REVIEWS

### **Fever Therapy.**

By H. Worley Kendell, M.D., F.A.C.P., 101 pp. Price \$2.25, Charles C. Thomas, 1951.

This monograph by Dr. Kendell is one in a series of "American Lectures in Physical Medicine". It is essentially a handbook for the physician or student, and relates almost entirely to methods of physically induced fever. Biologic means of therapy, such as malaria, are only mentioned in passing.

There is an adequate, brief discussion of the principles of fever therapy, techniques, and complications. Therapeutic indications are also summarized, but in his summary Professor Kendell emphasizes treatment by physically induced fever of several diseases which are now treated almost exclusively by other means. He suggests that fever is virtually the treatment of choice for early syphilis and neurosyphilis, where he recommends its employment in conjunction with chemotherapy or penicillin. The same recommendations are made with regard to gonococcal infections. Actually, most venereologists now consider penicillin so effective that fever therapy is rarely needed.

Within its limited field of clinical usefulness, Dr. Kendell's monograph on fever therapy is a concise and useful technical summary.

GEORGE HILL HODEL, M.D.

### **Clinical Heart Disease.**

By Samuel A. Levine, M.D., F.A.C.P., 4th Edition, 556 pp. with 192 figures. Price \$7.75. W. B. Saunders Co., 1951.

This fourth edition of Clinical Heart Disease has kept pace with recent advances in this field. The author's vast clinical experience enables him to present his subjects in a clear, concise manner. This book offers an exceptionally good guide for anyone interested in the clinical aspect of heart disease or who has cardiac problems to cope with. The chapter on electrocardiography is very well presented. Illustrations are good.

HENRY C. GOTSHALK, M.D.

### **The Physiology of the Newborn Infant.**

By Clement A. Smith, M.D., 2nd Edition 365 pp. with 52 illustrations. Price \$7.50. Charles C. Thomas, Publisher, Springfield, Illinois, 1951.

This work is most soundly based on research, clinical experience, wide reading and eminently sound thinking.

It is conveniently arranged, taking up the various aspects of neonatal physiology under separate headings. At the end of each chapter there is a summary of the topic under discussion. It is for that reason an excellent reference work.

For a thorough understanding of the fundamental underlying physiologic factors of neonatal life this book cannot be too highly recommended.

DONALD C. MARSHALL, M.D.

### **Emotional Factors in Cardiovascular Disease.**

By Edward Weiss, M.D., 84 pp. Price \$2.25. Charles C. Thomas, 1951.

Once again a psychiatrist attempts in a brief summary to impress the doctors of medicine with the importance of emotional factors in relation to functional and organic disease of the cardiovascular system. Also stressed is the value of finding the positive factors of emotional etiology often preceding cardiovascular pathology rather than ignoring them when negative evidence of organicity is found through examination and laboratory tests. These points are well emphasized to the reader through the use of interesting case studies scattered throughout the book. Dr. Weiss has carefully and methodically discussed the various symptoms arising from disease and dysfunction of this system which will help the physician to be more certain in his diagnosis and treatment of the patient.

Although the book offers nothing really new in psychosomatic medicine, it is a good review of present day knowledge of this important body system.

H. JOSEPH SIMON, M.D.

### **Food Allergy.**

By Herbert J. Rinkel, M.D., Theron G. Randolph, M.D., and Michael Zeller, M.D. 497 pp. with 25 illus. and 182 recipes. Price \$8.50. Charles C. Thomas, 1950.

This excellent treatise on a subject of prime importance to not only allergists but also physicians in other fields, is most refreshing. The quality of material and case findings presented are clear cut and to the point, and attest to the vast experience the authors have had in the methods described for the diagnosis and management of allergies due to foods. Their findings and clinical observations are based on over fifty thousand individual and deliberate food tests. Under diagnostic methods, specific instructions are given how to prepare foods for individual ingestion tests. The importance attached to the minutiae of the preparation of the patient for specific testing as well as the food to be tested is brought out clearly. The book is replete with menus, and recipes for various types of food intolerances. These are tried and true formulae and are of inestimable value to every physician who handles food allergies.

The book is divided into seventeen chapters with an appendix covering laws on the preparation of foods, drugs and cosmetics under the Federal Food, Drug and Cosmetic Act. This appendix is valuable as a reference source.

The book fulfills its intended purpose; first, to describe in terms of the authors' experience the nature and dynamic mechanism of food allergy, and second, to outline a practical approach to the problems inherent in the recognition and management of food allergies.

TELL NELSON, M.D.

# **The Kidney—Medical and Surgical Diseases.**

By Arthur C. Allen, M.D., 583 pp. with illustrations.  
Price \$15.00. Grune & Stratton, Inc., 1951.

This is one of the most refreshing and useful monographs on the kidney published in recent years. Over one half of the 583 pages are devoted to plates illustrating the embryology, anatomy and pathology of the kidney with numerous photomicrographs. The illustrations are clear, distinct and chiefly original. The text and bibliography are printed in double column and permit easy reading.

Allen's text on the various aspects of the kidney is well done. He has carefully reviewed the embryology, anatomy, normal and pathological physiology and the various medical and surgical diseases of the kidney, supplemented with unusually clear and well chosen photographs. The discussion on the physiology and the vascular diseases are not only timely but classical. Allen aimed at the presentation of a dynamic pathology—as contrasted to a dry descriptive pathology—and the correlation and integration of the many newer developments concerning the diseases of the kidney. The sections on the surgical diseases are not as complete as a urologist would desire. Renal calculus is discussed rather briefly (6 pages) though many of the salient features are mentioned. Renal tuberculosis is discussed in a page and a half. Renal tumors are given more space (14 pages) but the greater part is devoted to the rarer conditions. Urinary stasis certainly deserve more than a cursory passing remark. The author has emphasized the dynamic pathology of the medical aspect rather than the surgical aspect. The book, therefore, has limited usefulness to the urologist. I would highly recommend this beautiful atlas and monograph on the medical and surgical diseases of the kidney to those who are interested in the dynamic pathology of the kidney.

SHOYEI YAMAUCHI, M.D.

# **Physical Diagnosis.**

By Raymond W. Brust, A.B., M.D., F.A.C.P., 300 pp. with 71 illustrations. Price \$4.50. Appleton-Century-Crofts, Inc., 1951.

The science of physical diagnosis has long been a neglected art. This is due principally to the increased use of machines as modern diagnostic aids. It has been our tendency to subordinate the simple direct approach that a careful physical examination can offer in the solution of a medical problem for readings obtained by a complicated electrical or mechanical instrument, or a therapeutic trial with one of the newer antibiotic drugs.

In this book the author follows a definite pattern similar to that used by many physicians in actual practice. The book is written not only for medical students but for practicing physicians interested in doing a good physical examination and using a systematic approach to their medical problems.

HENRY C. GOTSHALK, M.D.

# **Clinical Tropical Medicine.**

Edited by R. B. H. Gradwohl, M.D., L. Benitez Soto, M.D., and O. Felsenfeld, M.D. 1647 pp. Price \$22.50. The C. V. Mosby Co., 1951.

Originally planned as a Pan-American work, this excellent text has turned out to be a world-wide one in the distribution of its 57 contributing authors. Specialism is more and more having its effect on the book-writing

business, and each subject in this text is dealt with a specially qualified author, with plenty of good illustrations and adequate bibliographies. The orderly mind and teaching proclivities of the senior author are apparent in the methodical organization and clear presentation of the material prepared by each author. There is a special section of laboratory procedures and modifications of them for use in tropical areas.

HARRY L. ARNOLD, JR., M.D.

# **A Review of Medicine. (Revised)**

By Benjamin Boshes, M.S., Ph.D., M.D., 814 pp. Price \$15.00. Members of the Faculty of Northwestern University Medical School, 1951.

The sixth edition of this eighteen year old compendium of general medicine is an entirely new and up-to-date version.

It is too concise to be useful to practitioners. Its principal value is as a text for rapid review of general medicine, particularly for taking examinations. For this purpose it is excellent. The pages are large, the type is clear and the material is completely free of verbiage.

HARRY L. ARNOLD, JR., M.D.

# **Post-Graduate Lectures on Orthopedic Diagnosis and Indications, Vol. II.**

By Arthur Steindler, M.D., F.A.C.S., 208 pp. with 209 illustrations. Price \$6.00. Charles C. Thomas, 1951.

This second volume by Dr. Steindler is an excellent addition to his series. These volumes are collections of lectures and are not designed as textbooks. As such they make for easier reading.

An excellent discussion of anterior poliomyelitis covering all phases of the disease is made. In this section the author makes a clear evaluation of the Kenny method and its place in the treatment of anterior poliomyelitis.

Dr. Arthur Steindler is one of the old masters in orthopedic surgery. These lectures condense his ideas into as few words as possible. The book is well done.

B. ALLEN RICHARDSON, M.D.

# **The Diagnosis and Treatment of Adrenal Insufficiency.**

By George W. Thorn, M.D., 2nd Edition, 180 pp. with 25 tables and 32 figures (2 in full color). Price \$5.50. Charles C. Thomas, 1951.

This monograph is of attractive size and arrangement for quick review of up-to-date information concerning adrenal insufficiency. It is more comprehensive than an ordinary text book of medicine, and contains more recent information than most chapters in loose-leaf medical systems. It is certainly more convenient to read in a horizontal position.

Physiology and biochemistry of the adrenal gland is succinctly presented. The major part of the book deals with clinical and laboratory considerations of diagnosis and therapy. Brief case presentations and good illustrations add interest. The didactic presentation of material and tabulation of data (including costs of therapy, excluding of course doctor's bill) do not decrease the attractiveness of the presentation unduly.

S. E. DOOLITTLE, M.D.

(Continued on Page 40)



# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## COUNCIL MEETING

Thursday, July 19, 1951 at 6:00 p. m.  
The Pacific Club

Dr. Harry L. Arnold, Jr., presiding; Drs. Tilden, McArthur (Maui), Wade (Kauai), Gotshalk, Ito, R. K. C. Lee.

*Medical Consultant to DPW:* Dr. Arnold announced that he had received a letter from Mr. Ernest N. Heen, Director of the Territorial DPW, asking the assistance of the Territorial Medical Association in the selection of a medical consultant for the DPW's Aid to the Permanently and Totally Disabled.

**ACTION:** It was voted to refer the matter to the Honolulu County Medical Society.

*Approval of Imua Program:* Dr. Arnold reported the basis and aims of the IMUA organization, and stated that recently the Honolulu County Medical Society, after being asked to sign a statement of approval of IMUA's purposes, had discussed it at some length and voted to table a previous motion to accede to the request. Dr. Wade felt that reply should be made to the effect that while individual members of the Territorial Association are in sympathy with IMUA's objectives, it is not compatible with the aims of the Association itself to enter into matters of a political nature. Dr. Gotshalk felt if this were done now, it would not only tend to discourage such requests in the future, but would set a precedent.

**ACTION:** It was voted that the Council go on record as opposed to entering into any such non-medical activity, and that requests for such support should be met on an individual basis, i.e., by individuals of the Association, only.

*Delegates' Reports of AMA Convention:* The reports of Dr. Hartwell and Dr. Izumi were circulated. Dr. Arnold mentioned that the delegates had done an excellent job at the AMA convention. A short informal discussion regarding liaison between individual physicians and the Veterans' Administration followed.

*Improved Professional Opportunities:* Dr. Arnold characterized a letter recently received from the Chamber of Commerce on the above subject, as a sincere effort on the part of that organization to be of aid to the Medical Association. Dr. Wade stated he believed the entire program should be referred to the Public Relations Committee.

**ACTION:** On motion of Dr. Lee, seconded by Dr. Tilden, it was voted to refer the matter to the Public Relations Committee.

*HTMA Annual Merit Award:* In 1948 Dr. H. McLeod Patterson first brought up the matter of a Distinguished Service Award for physicians in the Territory who through the years, have given service "far beyond the call of duty". Dr. Arnold stated he felt this is too small a community to embark on such a matter and Dr. McArthur remarked that friction might ensue over the naming of the honoree from time to time. All

members of the Council agreed it would be difficult to make such an award now, since there were many physicians who distinguished themselves during and after Pearl Harbor, who had received only token recognition or none at all from the government. Therefore, no action was taken in the matter.

*Conference of State Journal Editors:* Conferences of State Journal Editors were held a few years ago, but were discontinued after the first two, and will start again in November this year. Dr. Arnold felt that such meetings are of great value to journal editors. The financing of such a trip was not included in the yearly budget, however.

**ACTION:** It was voted that if the funds permit, without a special assessment, the Council approve sending Dr. Arnold to the Conference in November; also, that a letter be written to the Board of Medical Examiners to ascertain if funds for the trip could be advanced by their treasurer.

*Employee's Salary Increase:* Miss Florence Isoda, assistant to the executive secretary of the HTMA, has been serving most acceptably in that capacity for six months, and a salary increase was requested for her.

**ACTION:** It was voted that Miss Isoda's salary be increased \$25.00 per month, and be reviewed in another six months.

*Payment, Disaster Relief Agency's Cards:* A letter from Dr. Dorian Paskowitz of the Territorial Disaster Relief Agency was read, requesting payment of Fisher Corporation's bill of \$11.00 for the printing of 500 attendance cards for the course presented on Oahu and Maui on "Medical Aspects of Atomic Explosions."

**ACTION:** The Council unanimously approved the payment of the aforementioned invoice.

*Smallpox Vaccination Exceptions:* A recent letter from Dr. Wilbar, President, Territorial Board of Health, regarding smallpox vaccination and immunization of school children, was read. The letter requested the Association's views on the danger from epidemic diseases if exceptions are permitted to religious groups, as are presently provided for.

It was the consensus of opinion that there is a continuous potential danger to epidemic disease, and that no exceptions should be made to any group or groups in carrying out the vaccination and immunization programs.

*Executive Secretary Pro Tem:* Dr. Arnold requested approval of the appointment of Mrs. Florence Gray who was employed on a trial basis as executive secretary pro tem, to replace Mrs. Edith Bennett, executive secretary now on leave of absence.

**ACTION:** On motion duly made and seconded, the appointment was unanimously approved.

I. L. TILDEN, M.D.  
Secretary

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 309th regular meeting of the Hawaii County Medical Society was called to order by the President, **Dr. T. David Woo**, at 7:45 p.m., June 21, 1951, at the Staff-room of Hilo Memorial Hospital.

A letter from the Hawaii Island Chamber of Commerce dated May 10, 1951 extended an invitation to members of the Medical Society to join the Hawaii Island Chamber of Commerce. The letter further stated that there is a "possibility of creating a medical division without jeopardizing the autonomous status" of the society. Following a short discussion it was voted that the Society write a letter to Co-chairmen Keith Abe and Donald Gedge of the Membership Committee of the Hawaii Island Chamber of Commerce stating that their letter has been received and taken under advisement.

A letter from **Dr. A. S. Hartwell**, Secretary of the Hawaii Heart Association dated June 5, 1951, inquired "whether or not the members of the Hawaii County Medical Society are in favor of arrangements being made for another Cardiac Clinic in Hilo sometime this summer." It was voted that the Society go on record as favoring another Cardiac Clinic in Hilo this summer. It was also voted that the cardiologist come over to Hilo next month at the time of the next regular meeting if possible so that he can speak before the members of the Society.

The business portion of the meeting ended at 8:14 p.m. This was followed by an interesting and instructive talk by **Dr. G. N. Stemmermann**, pathologist at Hilo Memorial Hospital, on male sterility—its causes, diagnosis, and treatments.

The 310th regular meeting of the Hawaii County Medical Society was called to order by **President T. David Woo** at 8:10 p.m., July 26, 1951 following a dinner at the Hilo Country Club. **Dr. A. S. Hartwell**, **Dr. K. Kuramoto**, **Dr. M. A. Glover**, and **Mr. Dahlquist** of the Hawaii Heart Association were present as guests.

A letter dated July 12, 1951 from **Dr. Dorian Paskowitz** concerning the course on "Medical Aspects of Atomic Explosions" was read and discussed. **Dr. Henry Yuen** moved that a Committee of three be appointed to study the situation further before any decision is made. This motion duly seconded, was passed unanimously.

**Dr. Nicholas Steuermann**, a transferee from the Kauai County Medical Society, was accepted into this Society by unanimous vote.

The film, "Guard Your Heart," was then shown. This was followed by talks on "Congestive Heart Failure" by **Drs. K. Kuramoto** and **A. S. Hartwell**, cardiologists from Honolulu.

The question of moving the present Library at Hilo Memorial Hospital to the new Puuamale Hospital was brought up for discussion. After comments from different members, **Dr. M. H. Chang** moved, seconded by **Dr. H. Yuen**, that the Library remain at its present site. Motion carried.

An election was held for a replacement on the Disaster Council for **Dr. Leo Bernstein**, resigned. **Dr. H. Yuen** was elected.

The 311th regular meeting of the Hawaii County Medical Society was called to order by President **T. David Woo** at 7:55 p.m. Thursday, August 9, 1951 in the Staff-room of Hilo Memorial Hospital. Guests present were **Dr. T. Althausen**, Professor of Medicine at the University of California, **Dr. F. A. Rovenstine**, Chief of Anesthesiology at Bellevue Hospital in New York, **Dr. Robert Faus** of Honolulu, **Mrs. R. Tucker** of the local HMSA office, and **Dr. M. Glover**.

Since there was no new or old business to take up, the meeting was turned over to **Dr. Althausen**. He gave an hour's talk on the "Differential Diagnosis of Abdominal Pain." This was followed by a talk on "Nerve Block" by **Dr. Rovenstine**. Both talks were well received.

The remainder of the evening was then turned over to **Dr. Robert Faus**, who gave an over-all picture of the workings of the HMSA for 1950, supplemented with statistics. He also informed the Society of certain irregularities going on among certain doctors on this island concerning HMSA claims. He suggested that this Society take initiative in correcting the situation. After a short discussion, **Dr. Crawford** moved that any irregularities which the HMSA wished to interpret be referred to the Grievance Committee of the Hawaii County Medical Society for study and recommendation. **Dr. S. R. Brown** amended this motion by adding that the HMSA submit to the Society certain information and data with an analysis of the irregularities noted by the Hawaii Medical Service Association. The motion was seconded by **Dr. W. Bergin** and passed unanimously.

FRANCIS F. C. WONG, M.D.  
Secretary

## HONOLULU COUNTY MEDICAL SOCIETY

The August meeting of the Society was held on August 3, 1951, at 7:30 P.M., in the Mabel Smyth Auditorium with **Dr. John Wm. Devereux** presiding and approximately 100 members and guests present.

The following amendments to the By-Laws of the Honolulu County Medical Library were unanimously approved:

### ARTICLE I (Membership)

"The Board of Governors may elect to honorary membership any of the following persons: (1) Persons who have rendered outstanding service to the Library."

### ARTICLE II (Board of Governors)

"The Board of Governors shall consist of not less than seven nor more than fifteen members, of whom at least four shall be elected each year to serve for three years."

The scientific program was as follows:

"Electro-Stimulation Therapy in Barbiturate Poisoning"—**Dr. J. Robert Jacobson**.

"Report of the AMA Convention"—**Dr. A. S. Hartwell** and **Dr. Homer Izumi**.

"Investigation of British Health Service"—**Dr. Steele Stewart**.

"Therapy with Procaine and Its Derivatives"—**Dr. E. A. Rovenstine**, Professor of Anesthesiology, Bellevue Medical Center, New York.

Meeting adjourned at 10:30 P.M. to refreshments on the Lanai.

WILLIAM S. ITO, M.D.  
Secretary



### KAUAI COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital at 7:30 p.m. on Wednesday, July 11, 1951 with President **Dr. K. Fujii** presiding.

There were four guest speakers: **Dr. H. E. Bowles, Dr. Duke Choy, Dr. R. B. Faus, and Miss Rubbelke.**

**Dr. Choy** spoke on the "Care of Premature Infants."

**Miss Rubbelke** spoke on "Nursing Care." Subjects presented were: (1) Emotional stabilization in the mother, (2) Prevention and treatment of infections, (3) Nutrition during labor, (4) Temperature stabilization in the incubator, (5) Care of prematures after leaving hospital, etc.

**Dr. Bowles** followed with his talk on obstetrical problems in prematures.

The meeting was concluded with **Dr. Faus'** report on the H.M.S.A. He spoke of the present financial condition of the Association and the unalleviated trend in benefit payments, retention of the \$35,113.72 balance of withholdings from the physicians during the second half of 1950. In addition, he recommended that these withholdings be continued and further refunds be deferred until the effect of the benefits and dues revisions has had time to be reflected in the operations. The Executive Committee took action to increase non-group dues effective August 1, 1951, to a full 25% differential over group dues and to discontinue medical benefits to non-qualifying groups and individual non-group memberships.

He said that the administrative and operating costs are being held to the lowest percentage of income in the history of the Plan.

He mentioned that there are 9 doctor members representing the four County Societies, who are on the Board of Directors and who constitute the Medical Committee.

He further stated that a revision of fee schedule is contemplated in the near future, that each physician will become a participating physician in this Revision contract. Application blanks will be forthcoming which are to be forwarded to the Secretary of the local society who in turn shall forward the list to the H.M.S.A.

The regular meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital at 7:30 P.M. on Wednesday, August 8, 1951, with President, **Dr. K. Fujii**, presiding. Guests were: **Dr. Kim, Mrs. Hardy, and Dr. Takanishi.**

A letter from the Hawaii Heart Association was read regarding the next heart clinic. Discussion followed. To secure a clinic similar to the one held on the previous occasion was satisfactory to all. Arrangement for patients and a definite date for sometime after September 9, 1951, was to be made after consulting Miss Middleton, Superintendent of Wilcox Memorial Hospital.

The question of ambulance service arose once again without any definite solution.

**Dr. Wade** brought up the subject of the type of membership now existing in the Constitution and By-Laws. It was his contention that there was one in connection with the military, that is, a membership status for those temporarily stationed in the armed services—this along with the active and honorary membership. According to the By-Laws at hand, there is no such designation. It was his opinion that an amendment should be added to the present By-Laws in the event such was not the case. Perhaps another set of By-Laws existed. It was

decided that **Dr. Wade** investigate whether there are co-existing By-Laws.

**Mrs. Kay Hardy**, pathology technician at the Mahelona Hospital, whom the Kauai chapter of the Hawaii Cancer Society sent to the mainland earlier this year to study cancer diagnosis, and who will administer the cancer detection laboratory, reported on her studies.

**Miss Hee** from the Board of Health spoke on her department's activities. In view of the tremendous amount of work with a limited personnel she sought aid in order to decrease some of the work and concentrate on public education. **Drs. Kuhlman, Wade and Masunaga** mentioned the fact that there have been duplications in the work performed both by her department and the various physicians, and that perhaps some of the burden could be lightened by adjusting this part of the program. Other suggestions presented were: Proper co-ordinated assignment of nurses, carefully planned transportation, omission of lengthy duplication of cases, notes, etc.

**CLYDE H. ISHII, M.D.**

*Secretary*

### MAUI COUNTY MEDICAL SOCIETY

Regular meeting of the Maui County Medical Society was called to order by President **Dr. E. Shimokawa** at 9:00 p.m. on July 11, 1951, at the Club El Amigo.

Guests present were: **Dr. Bernstein, Mr. Bradfield, Dr. Miura, Miss A. K. Hew, Jazz Belknap, F. Kage and M. Paschoal.**

**Dr. Bernstein**, director of the Hospital Care Division of the Department of Health, discussed in detail Act No. 129 regarding the care of indigents and the medically indigent. **Mr. Bradfield**, Administrative Assistant, also gave a short talk on this subject.

Following this discussion, a short medical meeting was called by the president. Minutes of the previous meeting were approved as circulated.

A letter from **Dr. Hartwell** of the Heart Association, requesting another cardiac clinic on Maui, was read. It was voted that we ask the Heart Association to send cardiologists for another clinic to be held at the Puu-nene Hospital on the third Tuesday afternoon of August.

A letter from **Mrs. Edith C. Bennett** regarding the qualification of physicians in chest X-ray interpretation was read. Members were requested to fill out application blanks if they desired to become eligible as interpreters of food handlers' chest X-rays.

The medical society unanimously approved the fluoridation of public water supply in compliance with the Resolution passed by the Association of State and Territorial Health officers.

It was voted that the medical society go on record as concurring with the decision of the local Chapter of the National Foundation for Infantile Paralysis on the grounds that funds are insufficient at the present time.

**Dr. St. Sure** reported on behalf of the Pathology Committee with reference to obtaining a pathologist. It was requested that **Dr. Fleming** discuss this matter with the Malulani Hospital Medical Staff and suggest they employ a temporary pathologist from Honolulu until such time as the new hospital is completed and Malulani Hospital has a place for a pathologist.

The Society unanimously voted to continue the Quarterly Cumulative Index Medicus.

**SEIYA OHATA, M.D.**

*Secretary, Pro-tem.*

# NOTES AND NEWS

## PERSONALS

**Dr. Leo Bernstein** in June became head of the Territorial Department of Health's new Division of Hospitals and Medical Care. He is faced with the job of making less than 3 million dollars buy over 4 million dollars worth of medical care for the indigent and medically indigent in the current biennium.

Licensed in June to practice medicine in Hawaii were **Drs. David K. Geddes, Mary A. Glover, Harry Lee** and **James Rutherford**.

**Dr. Vernon Jim** of Wailuku, with Mrs. Jim and Arleene and Sandra, left Hawaii in June for further postgraduate studies at the University of Chicago.

**Dr. John J. Lowrey** was recently elected President of the Harvard Club of Hawaii.

**Dr. Steele Stewart** returned in June with Mrs. Stewart from a European tour extending from Lisbon to Reykjavik, during which he presented a paper at an international orthopedic meeting in Stockholm, Sweden.

Recently returned from mainland trips for rest and postgraduate studies and clinic visits are **Dr. C. M. Burgess, Dr. Fred Giles, Dr. R. B. Cloward, Dr. Art Molyneux, Dr. Peter Washko, Dr. Louis Gaspar, Dr. Lyle Phillips, Dr. Colin McCorrison**.

**Dr. Robert C. H. Lee** was awarded the Atherton Trophy for his stamp collection at the philatelic show held last June.

**Dr. Pauline Stitt**, for six years head of the Bureaus of Maternal and Child Health, and Crippled Children, left the Health Department in July. She plans to attend the international Poliomyelitis Congress in Copenhagen and will represent Hawaii and the United States at the world congress of the International Society for the Welfare of Cripples. Aloha, Pauline!

**Brigadier General Harold H. Twitchell**, who has commanded Tripler Army (formerly Tripler "General") Hospital since the new building was opened in 1948, was replaced last July 14 by **Colonel Thomas J. Hartford**. General Twitchell's tour of duty here has been marked by the most cordial and cooperative relations between military and civilian medical services.

Our deepest sympathy is extended to **Dr. Archie Orenstein** of Hilo, who lost his son, Morton, in an airplane crash in June, and to **Dr. John J. Lowrey**, whose wife, Kitty, died May 30 after a prolonged illness.

**Dr. Thomas T. Tennant**, who interned at The Queen's Hospital, started private practice at Maunaloa, Molokai, early in July.

**Dr. Philip M. Corboy** has recently been doubly honored by being named French Consul in Hawaii and by election to the position of Commander of the American Legion here.

**Dr. Lucida Z. Cuajunco**, daughter of a professor at the college of medicine of the University of the Philippines, recently started a residency at St. Francis Hospital.

**Dr. Alfred S. Hartwell** spent a few days in the hospital in July recuperating from injuries received in July when his car was struck by another.

**Dr. and Mrs. Raymond M. deHay** left in July for Berkeley, California, where he will take further hospital training.

**Dr. and Mrs. Cyrus Loo** welcomed their second child, a son, on July 7.

**Dr. Kameichi Takenaka** has accepted an appointment as pediatrician in the Bureau of Maternal and Child Health of the Territorial Department of Health.

**Dr. Max Levine**, Chief of the Bureau of Laboratories of the Territorial Department of Health, gave a paper before the Society of American Bacteriologists in June on the subject of serologic studies in leprosy, and participated in several conferences and discussions during the meeting.

**Dr. Roy R. Ohtani** has recently opened his office at 1610 South King Street, where he will continue in his specialty, pediatrics. He is a graduate of Tulane University and has served residencies at Lincoln and Bellevue Hospitals, New York, University of Colorado Medical Center, Denver, and Kauikeolani Children's Hospital, Honolulu.

**Dr. Clarence W. Trexler** returned from his vacation July first. While away he attended the 25th reunion of his class at the University of Virginia.

**Dr. William F. Leslie**, of Hilo, was re-elected Governor of the American College of Chest Physicians for the Territory of Hawaii at the annual meeting of that organization at Atlantic City, and **Dr. Hastings H. Walker** of Honolulu, was re-elected Regent of the College for District No. 16.

**Dr. Kenneth H. Rusch**, of Honolulu, was recently honored by election to membership in the American Psychiatric Association.

The principal address on the occasion of the opening of the new Puumale Hospital for Tuberculosis, on July 28, was delivered by **Dr. Hastings H. Walker**.

**Dr. Kwan Heen Ho** was recently elected Commander of Kau-Tom Post 11 of the American Legion.

**Dr. M. Yamashiro** took \$15,000 worth of medical equipment and supplies, donated by the Hawaii-Okinawa Relief Association, to Okinawa in June. Dr. Yamashiro is the founder and leading supporter of the Association.

**Dr. Louise S. Childs** was honored in July by election to fellowship in the American Academy of Pediatrics. She left in mid-August to accompany her husband, **Dr. Edgar Childs**, to Philadelphia, where he will take postgraduate work in roentgenology.

**Dr. Richard K. C. Lee**, executive officer of the Territorial Board of Health, left for Copenhagen in August to attend the Second International Poliomyelitis Conference as a representative of Hawaii Chapter of the National Foundation for Infantile Paralysis.

**Dr. John C. Milnor** was married in June to Miss Hazel Spencer of San Francisco. Dr. Milnor recently returned from his postgraduate studies in Washington, D. C., and at the Mayo Clinic, to resume practice in the pediatrics department of The Clinic in Honolulu.

**Cmdr. William H. Gullede** left Honolulu in July for a tour of duty in Maryland. He had been resident in orthopedic surgery at the Shriners' Hospital for Crippled Children.

**Dr. George Ewing** returned from the mainland early in August to join the pediatrics department of The Clinic. He was graduated from Washington University



at St. Louis in 1946, and served an internship at Queen's Hospital, 1946-1947. The following two years he spent as a Lieutenant (jg) in the Navy, the last half of this time as a flight surgeon at Kaneohe Naval Air Station. From 1949 to 1951 he was a Resident in pediatrics at Children's Hospital in St. Louis. Mrs. Ewing is a Missouri girl. They have no children.

**Dr. and Mrs. Philip S. Arthur** welcomed a son on July 9.

### HELP WANTED, MALE OR FEMALE

The position of Assistant Editor of the *Hawaii Medical Journal*, recently vacated by the reluctant resignation of the incumbent, **Dr. Laurence Wiig**, is now available for occupancy by some alert physician. The duties consist of preparing the items of this Notes and News section. The salary is modest, the opportunity for graft is limited, the work is light and intermittent.

## Hawaii

### Doctors Who Can Travel

**Dr. Margaret Carlsmith** arrived in Hilo on July 31, 1951, to visit her parents, Mr. and Mrs. Carl S. Carlsmith. Accompanying her was her husband, **Dr. T. L. Althausen**, Professor of Internal Medicine at the University of California in San Francisco. Dr. Althausen spoke to the Hawaii County Medical Society on August 9, 1951.

**Dr. and Mrs. L. T. Chun**, of Honolulu, were here on the Big Island for a vacation from June 14-19. Mrs. Chun is a former nursing instructor at the Kuakini Hospital Nursing School.

### Doctors Who Travel in Order to Work

**Dr. Mary A. Glover**, formerly of The Queen's Hospital staff, is now doing locum tenens for **Dr. L. R. Fernandez**, who is on leave of absence in the States. She will be covering the Hamakua district from July 14 to August 31. After that she will be at the office of Drs. Orenstein and Bergin in Hilo relieving **Dr. Orenstein** who is slated for an extended mainland vacation.

**Dr. Robert John Kaufmann** of Decatur, Ill., has succeeded **Dr. Bearden Cunningham** as physician of Hawaiian Agricultural Company in Kau, Hawaii.

**Dr. Kaufmann** is a 1946 graduate of University of Illinois Medical School in Chicago. He interned at the United States Naval Hospital, Great Lakes Naval Base in Illinois, and then had military service on the Pacific Islands of Guam, Truk, and Palao. Dr. and Mrs. Kaufmann and their three children are now residing in Pahala, Hawaii. Dr. Kaufmann was recently appointed government physician for the Kau district.

**Dr. Edwin Willett** is the new doctor at Hutchinson Sugar Plantation, Kau. He replaced **Dr. Fred Irwin**, who left August 1 for Montreal, Canada, to visit his son, who is a medical student at McGill University. Dr. Willett is a native of Lahaina, Maui. He received his pre-medical training at Washington State College and Georgetown University. He then served four years with the Army Air Corps as aerial gunnery instructor. He received his M.D. degree at George Washington University. After an internship at Bethesda Naval Hospital he served on active duty as a lieutenant (jg). Dr. and Mrs. Willett and their two children will reside in Naa-lehu as soon as housing facilities are available.

**Dr. R. P. Wiperman** volunteered for military service

and was called to active duty on July 27, 1951. Word has been received that he is already in Korea.

### Doctors Who Work

**Dr. John T. Jenkin** has been appointed as the government physician for Hilo City mauka succeeding **Dr. R. P. Wiperman**. Dr. Jenkin, from the state of New York, was stationed at the Hilo NAS for 15 months during World War II with the rank of Commander. He liked the superb Hilo weather so well that he returned to practice in Hilo in 1948. He is a Major in the Medical Corps with the 299th Regimental Combat team, Hawaii National Guard.

**Dr. B. M. Eveleth** was appointed temporary government physician for North Kohala, succeeding **Dr. Rollin S. Fillmore, Jr.**

**Dr. Gardner M. Black** of Kamuela was appointed government physician for South Kohala.

**Dr. Leo Bernstein**, Administrator of the Division of Hospitals and Medical Care, was honored at several aloha parties before his departure from the Big Island. The local Board of Health group wished him success, the Hawaii County Medical Society wished him good health, and the local county Supervisors gave him a "thank you" luncheon for a difficult job well done. Everybody has a lot of Aloha for Leo. We'll miss him.

## Kauai

**Dr. Patrick Cockett** has returned from a mainland trip during which time he took post-graduate studies at Cook County Hospital, Chicago, Illinois. He also attended the A.M.A. convention at Atlantic City.

**Dr. Clyde H. Ishii** has become the plantation physician at Kilauea, Kauai. His practice in Lihue, Kauai, continues during the morning hours as in the past.

**Dr. Webster Boyden** has returned from the mainland during which time he attended his son's graduation from Dartmouth College. He also attended the A.M.A. convention at Atlantic City.

## Women's Auxiliary to International College of Surgeons

Formation of a new Women's Auxiliary was announced today by the United States Chapter of the International College of Surgeons.

The Auxiliary will function for the first time at the 16th annual assembly of the United States and Canadian chapters of the College in the Palmer House, Chicago, September 10 to 13 inclusive. Leading surgeons from every major country of the world outside the "iron curtain" will attend the session and convocation.

## American College of Chest Physicians Essay Award

The Board of Regents of the American College of Chest Physicians offers a cash prize award of two hundred fifty dollars (\$250.00) to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest disease.

Five copies of the manuscript, typewritten in English, should be submitted to the executive office, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois, not later than April 1, 1952. The only means of identification of the author or authors shall be a motto or other device on the title page, and a sealed envelope bearing the same motto on the outside, enclosing the name of the author or authors.

### The American Dermatological Association Annual Prize Essay Contest

The American Dermatological Association is again offering a prize of three hundred dollars for the best essay submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate younger investigators to original work in these fields.

Manuscripts typed in English with double spacing and ample margins as for publication together with illustrations, charts, and tables, all of which must be in triplicate, are to be submitted not later than December 1, 1951. The manuscripts should be sent to Dr.

Louis A. Brunsting, Secretary, American Dermatological Association, 102-110 Second Avenue, Southwest, Rochester, Minnesota; those which are incomplete in any of the above respects will not be considered.

Competition in this prize contest is open to scientists generally, not necessarily to physicians.

The prize winning candidate may be invited to present his paper before the annual meeting of the American Dermatological Association with expenses paid in addition to the three hundred dollars prize. Further information regarding this essay contest may be obtained by writing to the secretary of the American Dermatological Association.

The next annual meeting of the American Dermatological Association will be held April 23-26, 1952, at the Broadmoor, Colorado Springs, Colorado.

## UMI MAKAHIKI I HALA\*

**Dr. Kenneth Amlin** who is associated with **Dr. B. O. Wade** at Waimea, Kauai, returned August 1 from the mainland where he spent three months at the New York Polyclinic, studying eye, ear, nose and throat. Dr. Amlin does not expect to specialize in this field, but hopes to improve the care of the plantation personnel. After his studies he motored through the Pacific Northwest.

**Dr. Archie Orenstein** was on the mainland spending two months at rest and study on the East Coast. **Dr. Ivar Larsen** took over during his absence.

**Dr. Thomas Cowan** made a combined business and vacation trip to the mainland for two months. While there he passed examinations of the American Board of Ophthalmology.

**Dr. Harold Moffat** returned from the Coast recently with his family. While there he took and passed the American Board of Ophthalmology examinations.

**Dr. L. Clagett Beck**, formerly Assistant Physician at Koloa and McBryde Plantations in 1939-40, returned to Kauai to replace Dr. Thomas H. Richert who left July first for Honolulu.

**Dr. W. N. Bergin** of Laupahoehoe, just returned from a four months' course of study in mainland clinics. He spent most of his time at Tulane and at Cook County Postgraduate School.

**Dr. Frederick Giles** from Mahelona Hospital, Kauai, has come to Honolulu and joined The Medical Group.

**Dr. Charles L. Wilbar, Jr.**, Director of the Bureau of Maternal and Child Health, returned after a year's study with Dr. Graeme Mitchell at the Children's Hospital, Cincinnati. Before returning to Hawaii he took the American Board examination in Pediatrics.

**Dr. R. B. Cloward** has joined the air-minded physicians of Hawaii, flying to California by Clipper and continuing by air to Chicago, to take the American Board examinations in Neurology.

**Drs. Tessmer and Fennel** took the American Board in Pathology this summer; **Dr. Doolittle**, the American

Board of Internal Medicine, and **Drs. Gaudin and Wilbar**, the American Board of Pediatrics.

**Drs. Wah Kai Chang** and **Fred K. Lam** celebrated last month the twentieth anniversary of their working together, an event which many of the doctors and their wives were invited to share, at a dinner given at Lau Yee Chai.

**Dr. Herbert Bowles** went to the mainland this summer to take the American Board in Obstetrics and Gynecology, and visited the University Hospital at Ann Arbor and the University of California Hospital in San Francisco.

Hawaii was well represented at A.M.A. convention in Cleveland. **Dr. Pinkerton**, delegate, **Dr. Phillips**, alternate delegate, and **Drs. Doolittle, Van Poole, Fennel, Tessmer, Cloward** and **Bowles** attended. They met daily at the "ulcerative colitis booth" after sessions and proceeded to lunch together. **Dr. Suliphant**, one-time pathologist at Kapiolani, completed the group of "Hawaiians".

The Territory has lost eight of its doctors to the Navy in the last few months, about one-third of those on the naval reserve list in Hawaii. Those doing active duty are **Drs. H. M. Chandler, R. Mansfield, Robert Millard, Joseph Palma, F. W. Thompson, Clarence Trexler, Rodney West** and **Paul Withington**. So far these men have not been required to leave the islands and are stationed at Pearl Harbor, the old Naval Station Dispensary and the Fleet Air Base.

Seven doctors were elected by popular vote at a regular meeting of the Society to guide the medical preparedness activities, viz: **H. L. Arnold, J. E. Strode, R. B. Faus, Nils P. Larsen, Paul Withington, F. J. Pinkerton, James F. Judd**.

In July the donations of **Dr. Middleton** of Wisconsin and **Dr. Ravdin** of Philadelphia, of \$100.00 each for projection apparatus, were turned over to the Mabel Smyth Building to apply toward the purchase of an Ampro motion picture projector costing \$1,200.00.

\* Ten years ago.



## BOOK REVIEWS

(Continued from Page 33)

### **Tuberculosis Among Children and Adults.**

By J. Arthur Myers, M.D., Ph.D., 3rd edition, 894 pp.  
Price \$12.50. Charles C. Thomas, 1951.

The third edition of this well known text is a revised and expanded version of a volume which originally appeared in 1930 under the title "Tuberculosis among Children." The reader will find most of the chapters composed in a very informal, pleasant and readable style, with convenient summations at their ends. The discussion of tuberculosis control in the several chapters devoted to this subject is excellent as are the chapters on tuberculosis and war and on first infection and reinfection among young adults.

The book has a number of conspicuous weaknesses, among which are a chapter on recent progress which devotes a paragraph of six lines to antibacterial therapy and none at all to resectional surgery. The chapters on mechanical therapy by Matson, cavernostomy by Steele and extrapleural thoracoplasty by Head are all quite obsolete and the one on resection by Clagett contains no reference later than 1945. The chapter on treatment which finally mentions streptomycin is also based mostly on older material.

This is a valuable teaching and reference text that would make a useful addition to the library of any thoughtful physician.

ROBERT N. PERLSTEIN, M.D.

### **Atlas of Tumor Pathology.**

#### **Tumors of the Peripheral Nervous System**

By Arthur Purdy Stout, M.D., 57 pp. with illustrations.  
Price \$.60, Armed Forces Institute of Pathology,  
Washington, D. C., 1949.

#### **Tumors of the Adrenal**

By Howard T. Karsner, M.D., 60 pp. with illustrations.  
Price \$1.00, Armed Forces Institute of Pathology,  
Washington, D. C., 1950.

"Next to personal instruction by experienced pathologists there is no better guide to the identification of neoplasms than carefully selected illustrations provided that they are accompanied by adequate explanatory legends." This last sentence is a direct quote from the introduction by Dr. Balduin Lucke. These atlases live up to their aim and are certainly valuable quick references. However, they are of little help to the beginner in pathology. The lack of color makes them of less general value than the Navy atlas previously reviewed here. Also, the cover is paper and the binding is very flimsy. However, there are holes punched into them so that they can be placed in a notebook. The print is large and easily readable. These would certainly be of tremendous help to any pathologist, but they appear to be of limited value to the general man or even to the specialist outside of the fields of pathology or oncology.

W. HAROLD CIVIN, M.D.

### **Medicine of the Year.**

Edited by John B. Youmans, M.D. Third Issue. Price \$5.00. J. B. Lippincott Co., 1951.

The scattering of new medical information throughout dozens of subspecialty journals has created the need for a yearly summary such as this. The advances made in the past year in the various fields of medicine and

surgery are reviewed by twenty-two top authorities. There is considerable reduplication. For example, in the section on Respiratory Diseases, Hobart Reimann informs us that the antihistaminics have no effect on the common cold. In the next chapter on Allergy by Harry Alexander and still later in Francis Lederer's review of Otolaryngology, we are re-informed of this fact. This defect is even more apparent with ACTH, Cortisone and the antibiotics.

However, the significant contributions that have been made in medicine and surgery are well reviewed. Most practitioners who wish to keep a broad perspective of medicine would be rewarded by reading this book.

FRED I. GILBERT, JR., M.D.

### **Clinical Pathology—Application and Interpretation.**

By Benjamin B. Wells, M.D., Ph.D. 397 pp. with 32 figs. Price \$6.00. W. B. Saunders Company, 1950.

This is an excellent book, both because the material included is good and because its approach to problems is clinical. The material is arranged according to the functional systems relating the best applicable laboratory studies to the various clinical pictures. The laboratory tests are then evaluated in the light of normal and abnormal changes.

The author has deliberately limited his presentation of laboratory procedures to those he feels are of practical clinical importance. He feels that the clinician needs help in selecting tests and reiterates that the laboratory cannot ever replace the diagnostician. "Insufficient or improper use of the laboratory is often evidence of ignorance; excessive reliance on laboratory results is proof of inexperience."

The scope of the book appears quite adequate, covering infectious diseases, including the enteric, venereal, and mycotic infections; diseases of the gastrointestinal tract; respiratory system; genitourinary tract; cardiovascular system; metabolic and endocrine diseases; the application of clinical laboratory studies to surgery and obstetrics. An appendix is added in which normal values are listed with a discussion of the liver function tests.

The book is an excellent reference for clinicians and pathologists alike.

GILBERT B. STANSELL, Major, MC, U.S.A.

### **A New Concept Regarding the Genesis of T, Ta, U Waves and ST Segments.**

By George W. Collen, M.D., 101 pp. Price \$5.00. The Esenstein Company, 1951.

This monograph is short, concise and readable. Its purpose is the introduction of a theory that the T wave is the sum of the energy of the repolarization and the electrical energy liberated from the mechanical movement of the ventricles; and that the mechanical movement of the ventricles is one of the major factors creating the energy necessary for repolarization.

The author's experiments with the chicken heart, as well as the many excellent diagrams and electrocardiographic plates, make this monograph an exceedingly interesting and worthwhile work. The results of the experiments demonstrating "currents of injury" in myocardial infarction are both unique and informative. For those interested in the practical aspects and applications of electrocardiography, this monograph is heartily recommended.

F. BERNARD SCHULTZ, M.D.

### Diabetes Mellitus.

By Garfield G. Duncan, M.D., 289 pp., 31 figures and 40 tables. Price \$5.75. W. B. Saunders Co., 1951.

A surprising wealth of material is contained in this rather small book. Its chapters are numerous and short, making it very easy to refer to any and all aspects of diabetes. Dr. Duncan includes all the more modern theories of etiology and treatment. He rather leans towards the Joslin physiological method of treatment, and mentions the clinical control method of Tolstoi only to condemn it.

This is the only textbook on diabetes which I have read that gives not only the principles of treatment, but also quite definite outlines for the clinical use of diets and insulin. The later trends of diets and the newer insulins are not only discussed, but their proper place in treatment is given in detail.

Another very favorable aspect of this text is its frequent use of italics to make it very easy for the busy reader to pick up the salient points of each and every section.

This book is recommended very highly, not so much for reference but more for day-to-day use by the general practitioner and the internist.

JOHN M. FELIX, M.D.

### A Text-Book of X-Ray Diagnosis.

By British Authors in Four Volumes, 2nd edition. Volume I, 434 pp. with 439 illustrations. Price \$12.00. W. B. Saunders Co., 1951.

The publication of this book completes the revision of the four volume textbook of roentgen diagnosis which has been a leader for over a decade. The title "Head and Neck" is misleading, as the organs of the neck, aside from the spinal cord, are covered in other volumes of the set. The illustrations are uniformly superior. The subject matter is an authoritative coverage which is presented in a most readable manner. Changes from the original edition are necessarily few because of the excellence of the first edition.

There is a lack of recent references in many of the bibliographies. The only completely new chapter in the book is on cerebral angiography. The parts on the nasal sinuses and the mastoids are very well worthwhile for radiologists and specialists in these fields, and the section on pyography in brain abscesses is very good. The amount of space given to technic seems excessive for a work of this type. The volume is one of the best available at present on the subject matter covered by it.

A. O. HAFF, M.D.

# Keleket

## The oldest name in X-ray



### X-Ray Apparatus Accessories — Supplies

## The LIEBEL FLARSHEIM Co.

### SHORT-WAVE DIATHERMY

Distributed by

**Wadsworth's**  
PHOTO MATERIALS  
SINCE 1925

1158 Fort St.  
Honolulu

Phone 5-6040  
or 5-6045

WRITE FOR FREE DETAILED LITERATURE





## WELCH ALLYN

Diagnostic Set  
No. 983

The league-leading hitter wouldn't maintain his batting average long using a tennis racket . . . or even an inferior bat.

Just so the doctor's skill needs and deserves the help of the finest instruments for accurate diagnosis without waste of time.

That is why more doctors have chosen the efficient Welch Allyn No. 110 Ophthalmoscope and the easy-to-use No. 216 Operating Otoscope than any other instruments of their kind ever made.

They are shown here in Welch Allyn's Sandura Case, which is far more durable and more compact than old-style cases, and designed to be sterilized inside and out.

## HOTEL IMPORT COMPANY

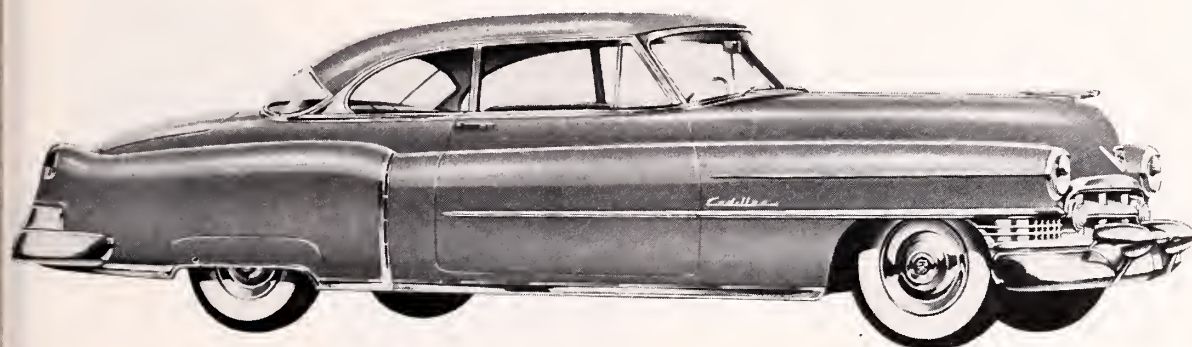
DIVISION OF THE VON HAMM-YOUNG COMPANY

718 Kawaiahao St.

Phone 6-3562

Honolulu, T. H.

*Rx Prescription for  
Cadillac —  
Put together the Finest  
Car America's  
automotive genius  
can create —*



*Cadillac*

Dependable, trouble-free, faithful . . . designed to relieve the owner from automotive worries and to perform with the utmost dependability in crisis or at leisure.

You might say Cadillac is "just what the Doctor ordered"—a precision tool for an important profession . . . a pleasure and a treasure for the years ahead.



**SCHUMAN CARRIAGE COMPANY**

Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU



SEARLE  
RESEARCH  
CREATED



"Smoothage"

**METAMUCIL®** —the refined bulk or "smoothage" principle now recognized as a preferred treatment for constipation—originated from Searle Research.

**METAMUCIL** is of plant origin—it adds necessary natural bulk to the food residue

is free of all forms of irritating substances

is prepared only in an easily dispersible powder which is taken with a glass of water or other liquids—one of the prime requisites to successful bowel management.

is economical—one teaspoonful one to three times a day in a glass of liquid is the indicated daily dose

enables the physician to use the "smoothage" principle of restoring normal bowel function

provides a bland water-retaining demulcent mass which mixes intimately with food and does not interfere with the digestion or the absorption of oil soluble vitamins.

**METAMUCIL IS A  
PROFESSIONAL PRODUCT.**



**METAMUCIL** is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE

RESEARCH IN THE  
SERVICE OF MEDICINE

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

## BULLETIN COMMITTEE

ANGELA M. STEMPEL, *Editor*, Leahi Hospital, Honolulu

LAURA DRAPER, *Nursing Information Committee*, Board of Health, Honolulu

LEAH BIGALOW, *Nursing Information Committee*, St. Francis Hospital, Honolulu

ALISON MCBRIDE, *Territorial Association Secretary*, Honolulu

### *Secretaries*

MARGARET BARNETT, Hawaii

VIRGINIA RAUTENBERG, Honolulu

PAULINE JOHNSON, Kauai

JOANN GROBERG, Maui

### *Publicity Chairmen*

EDNA BALDWIN, Hawaii

TSUGHI KADOTA, Kauai

ELIZABETH MCCALL, Maui

## PREOPERATIVE CARE AND ANESTHESIA

C. E. JOHNSON, JR., M.D.\*

The preparation of the patient for surgery should begin as soon as a diagnosis is made that indicates surgical intervention. All individuals concerned with the care of the patient should attempt to put him at ease and allay apprehension. Explanation of new experiences for the patient should be made beforehand so these experiences will not contribute to bewilderment nor fear.

### Medications Used Pre-operatively

Aims of pre-medication: (1) Sedation, (2) Control of pain, (3) Lower metabolism, (4) Control visceral reflexes of the autonomic nervous system. Dose varies with individual and contemplated anesthesia.

- Drugs: (1) Barbiturates—sedative and hypnotic  
(2) Opiates (e.g. morphine, demerol, methadon)—analgesic and lower metabolism  
(3) Belladonna derivatives—atropine suppresses vagal activities. Scopolamine suppresses the vagus and adds to amnesia and hypnosis and counteracts respiratory depression of morphine.

Study of patient should evaluate metabolic activity, liver and kidney function and oxygen carrying capacity of circulatory system. Abnormalities of function should be corrected insofar as possible before surgery.

### Choice of Anesthesia

Regional: (1) Topical—surface anesthesia only of mucous membranes

- (2) Local infiltration—analgesia in line of injection and incision only
- (3) Field block—wall of anesthetic solution surrounds area of operation in three dimensions
- (4) Conduction or nerve block—nerve supply to area of operation interrupted at distance from operative site (e.g. paravertebral, intercostal and brachial blocks)
- (5) Epidural block—nerves anesthetized on leaving the spinal cord sheath before they emerge from vertebral column
- (6) Spinal or subarachnoid block—anesthetic solution added to spinal fluid to bathe nerve roots and cord within the dura (sheath of spinal cord)

Regional anesthesia requires heavy premedication for patient cooperation and comfort. May be supplemented by hypnotic drugs for sleep such as sodium pentothal to produce "balanced anesthesia."

General anesthesia—Loss of consciousness and reflex activity due to drugs acting on the central nervous system as a whole.

Gases—Nitrous oxide—Low potency limits usefulness—Allows minimal dilution with oxygen non-inflammable. Pleasant to take. Ethylene—slightly more potent than nitrous oxide. Disagreeable taste and odor. Violently explosive. Cyclopropane—Full potency permits dilution with up to 75% oxygen. Explosive. Pleasant to take, very rapid in action. Poor muscle relaxation. Increases irritability of the heart.

Volatile Liquids: Ether—full potency—excellent muscle relaxation. Little effect on heart. Unpleasant irritating vapor in anesthetic strength. Explosive. Chloroform—Most potent agent. Excellent relaxation. Rapid action, pleasant to take. Decreases heart output and increases cardiac irritability. Non-explosive. Ethyl chloride—Similar to chloroform in action on heart. Explo-

\* Anesthesiologist, St. Francis Hospital.



sive. Vinethene—More rapid and pleasant in action than ether but useful only for short operations on induction of anesthesia. Explosive.

Liquids: Sodium penthotal and related barbiturates—May be given by vein or rectum. Produce only hypnosis in safe dosage, and do not reduce spinal reflex activities. Should be combined with other agents and oxygen rich atmosphere provided. Most pleasant induction. Variable recovery period. Avertin—Given by rectum for heavy premedication or basal narcosis. Expensive, variable in effects and largely replaced by barbiturates.

Relaxants: Curare and related compounds—Do not effect consciousness nor response to painful stimuli. Cause paralysis of muscles by blocking the neuro-muscular junctions. Enable surgery to be easily performed on a quiet relaxed patient with minimal general anesthetic.

## ANESTHESIA AND POSTOPERATIVE CARE AND OXYGEN THERAPY

C. E. JOHNSEN, JR., M.D.

Intelligent postoperative care requires knowledge of the effects of anesthesia and surgery and the untoward results that may arise. Local anesthesia, generally considered the safest form of pain relief for surgery, may be accompanied by disaster in the form of systemic reactions due to rapid absorption of large quantities or high concentrations of the drug. These reactions are either primarily of the nervous system or cardio-circulatory system. In the former instance, cerebral intoxication, excitement and delirium occur early followed by depression and coma. In excitement, there may also be convulsive seizures, treated by rapid-acting barbiturates intravenously administered. In depressed states, oxygen is advisable with artificial respiration as necessary in event of respiratory arrest. Cardiovascular collapse is usually manifest with immediate death. Cardiac massage and intracardiac adrenalin may be effective if they can be instituted immediately. If intracardiac adrenalin causes ventricular arrhythmias, small amounts of intravenous procaine may be used to counteract this though this procedure is not without danger in itself.

To understand the patient who returns to his room unconscious following a general anesthesia, it is helpful to be able to recognize the main signs of depth of anesthesia. These signs occur on emergence in reverse order to which they appear on induction of anesthesia and may be listed briefly as follows:

*First stage* of anesthesia is the occurrence of analgesia or reduced sensibility to painful stimuli. *Second stage* is marked by depression of higher brain centers with distortion of sensory perceptions and misinterpretation of events causing stimulus. The patient may become violently disoriented and

incapable of cooperation and must be protected against injury to himself. The *third stage*, that of surgical anesthesia, is characterized by progressive muscular paralysis and loss of reflex activity. The *first plane* of surgical anesthesia shows disappearance of swallowing reflexes and incomplete paralysis of the external muscles of the eyes so that the positions of the eyes may be excentric or roving. *Second plane* shows loss of vomiting reflexes, complete paralysis of external eye muscles so the eyes remained fixed in position. Respiration is regular with thorax and abdomen moving synchronously and machine like. *Third plane* shows progressive paralysis of the intercostal muscles leading to more and more of the burden of respiratory effort being placed on the diaphragm alone. *Fourth plane* shows complete paralysis of intercostal muscles and the diaphragm alone plunges down bulging the relaxed abdomen while the chest remains static or sinks in on inspiration. *Fourth stage* is characterized by complete respiratory paralysis and progressive failure of circulation.

The unconscious patient must be protected from respiratory obstruction as seen in noisy respiration or respiratory efforts without exchange of air being manifest. Obstruction may be caused by closure of nares and lips, relaxed tongue fallen in back of pharynx, laryngospasm, bronchospasm, pulmonary edema or pneumonia, or plugging of air passages by foreign material or excess mucus. An active cough reflex is protective against obstruction. Gravity should be used to aid not hinder the drainage of material from the tracheobronchial tree and pharynx. The pharynx, trachea and bronchi should be aspirated by suction if necessary, and occasionally under direct vision of laryngoscopy and bronchoscopy. Thumping of the patient's chest may aid in dislodging foreign material and stimulating active cough in presence of splinting and reluctance of patient to cough and breathe deeply because of pain. Carbon dioxide alone or with oxygen may be used to stimulate deep breathing in the uncooperative patient. Voluntary deep breathing can surpass the ventilation stimulated by carbon dioxide and should be encouraged. Changing of patient's position should depend on the condition of the patient in reference to effects of gravity on secretions in the tracheobronchial tree and effect on respiratory activity of the thorax. Plugging of a bronchus results in absorption of air from the lung areas supplied by that bronchus. This collapse is known as atelectasis and is a precursor to pneumonia in absence of recognition and treatment. Systemic signs of atelectasis are increased respiratory rate and pulse rate out of proportion to temperature rise.

Where ventilation is poor and oxygen cannot get to the tissues of the body due to respiratory obstruction, shallow or depressed respiration, or

circulatory embarrassment, oxygen therapy may be indicated. Oxygen therapy is based on the fact that oxygen diffuses in proportion to its density or concentration, and the rate of diffusion varies with the difference in concentration between two areas or solutions containing oxygen. Atmospheric air contains oxygen in sufficient concentration to cause arterial blood hemoglobin to become ninety-five to ninety-nine per cent saturated, sufficient for tissue requirements in presence of normal blood volume, hemoglobin content, and circulation. Defects in blood transport should have appropriate correction rather than reliance on oxygen therapy for any protracted period. Oxygen may be administered by insufflation, bag or mask, or tent. The most efficient form of insufflation utilizes a catheter placed in the nasopharynx so the multi-perforated catheter tip lies just behind the soft palate. For each liter of oxygen flow per minute, the oxygen concentration will be raised approximately 4% above the 20.9% of atmospheric air to a maximum of about 55% with 8 liters of oxygen per minute. Flow rates higher than this are uncomfortable and inefficient. The mask and bag affords the most efficient use of oxygen with concentrations to a theoretical 100% attainable. The apparatus varies in provision of valves, amount of rebreathing permitted, and metering of concentrations. A B.L.B. mask will give 50-60% oxygen at 4 liters per minute and 95-100% oxygen at 8 liters per minute provided the mask is well fitted to the patient's facial contours. An oxygen tent is most difficult to operate efficiently. An oxygen concentration within the tent of 45-50% is often assumed, but difficult of attainment. Fifteen liters of oxygen or more should be run for at least fifteen minutes on starting the therapy, and after each opening of the canopy for manipulation of the patient. If oxygen analysis can be done at least every three hours, it is sometimes possible to maintain a concentration of 45% oxygen at maintenance flows of 6 to 10 liters per minute. If analysis cannot be made, the oxygen flow should be maintained at 10 to 14 liters per minute.

Postoperative shock may be due to pain, changes in patient's position while the nervous system is still depressed by anesthesia, or by loss of circulating blood volume due to hemorrhage or extravascular loss of plasma from capillaries injured by physical trauma or anoxia. The cause of shock should be determined and treatment rendered accordingly. Vasodilatation may be alleviated by vasopressor drugs. Pain may be relieved by analgesics administered in small dosages intravenously, not hypodermically. Blood volume

should be restored by administration of blood or plasma. Oxygen should be given to minimize capillary and tissue damage during state of inefficient circulation and attendant anoxia.

Vigilance and intelligent observation are a constant requirement for those individuals responsible for the welfare of the patient before, during and after surgery.

## PREOPERATIVE AND POSTOPERATIVE NURSING CARE

LEAH BIGALOW, B.S., R.N.\*

In discussing preoperative and postoperative nursing care it is wise to decide what is the objective of such care, and we can perhaps answer this best by briefly stating that such care is concerned with those measures which are designed to increase the patient's comfort and safety, not only physically but mentally, while he is being prepared for, undergoing, and convalescing from an operation.

Once fortified with this objective, we find that the preoperative and postoperative nursing care of a patient follows more or less a general pattern. However, do not assume that there is only one correct way. There are, naturally, no "routine orders" which are applicable to every patient. One doctor may order his patient to resume a general diet gradually and another will order a general diet as tolerated on the patient's first postoperative day. What is routine for one physician may not be so for another. The nurse should familiarize herself with the individual doctor's requests. A good motto is: "When in doubt, ask."

The suggestions offered here are frequently used but are offered only as a working basis. Each hospital has certain individual procedures but generally speaking you will find them following similar methods. Therefore, let us admit a patient and see how we follow the objective that we have set for ourselves.

Our patient is admitted according to individual hospital procedures and assigned to his service. It is well known that fear, anxiety, and restlessness predispose to postoperative complications and that a person who is anticipating an operation is confronted with circumstances which will require mental and physical strength. The nurse should attempt to facilitate the patient's adjustment. Perhaps a good policy to proceed with in the initial admission is a businesslike manner, tempered with sympathy and consideration. It is not enough for the nurse to be armed only with technical knowledge. The principles of "Tender, loving

\* Instructor, St. Francis Hospital School of Nursing.



care" are as important today as they were fifty years ago.

Before operations can be undertaken a history, a general physical examination, and specific laboratory tests must be carried out. It is the nurse's responsibility to see that these routine procedures are ordered. It is not sufficient for her to merely send the requisitions to the correct departments, but she must follow through and see that these reports are on the chart before the patient is taken to the operating room, thus avoiding unnecessary last-minute confusion.

There are certain hygienic measures which are important in the preoperative preparation of a patient in order that postoperative complications may be avoided. These measures consist of general hygiene, with particular emphasis on the oral cavity, because it is known that pulmonary infections and parotitis are sometimes caused by an unclean condition of the mouth.

The diet varies with the condition of the patient. Nutritional deficiencies and dehydration are noted and whenever possible corrected before surgery. The patient usually receives a general nourishing diet up to and including the night before operation. Fluids are given freely until six to twelve hours before surgery in order to accumulate a reserve against the abnormal loss of fluids and the immediate postoperative inability to take fluids orally.

Preparation of the operative field involves shaving the skin and cleansing it. As to the exact method used, there is no specific procedure. Shaving should be done carefully to avoid nicking the skin, and any lesions near the field of the proposed operation must be noted. The essential factor to remember is to prepare an adequate field and see that it is cleansed thoroughly.

In order that both the stomach and the intestine may be as nearly empty as possible if the patient either receives a general anesthetic or is having abdominal surgery, an enema is usually ordered the night prior to surgery. It is important that the nurse note the returns and report it if inadequate results are obtained, because stomach contents may be vomited during the administration of an anesthetic, lower intestinal contents are apt to be evacuated with the relaxation caused by anesthesia, and a full bowel may cause obstruction to the operative field during abdominal surgery, to say nothing of predisposing to the postoperative complication of abdominal distention.

The immediate preoperative preparation begins the night before the operation and the nurse should plan her work so that the patient is insured

a good night's rest. There is a wide choice of drugs for sedation and they will vary with the individual doctor, the type of anesthesia used, and the patient's condition, as will all other medication orders.

Last minute preparations, such as the care of dentures and jewelry, administration of preoperative medications, and seeing that the bladder is emptied before the patient is transferred to the operating room, should be planned in such a manner that the patient will not feel that he is being hurried.

The details of the preoperative preparation, as well as the dose and time of administration of preoperative sedatives and medications, should be noted on the chart which accompanies the patient to the operating room.

Postoperative care begins in the operating room, where precautions are taken by the surgeon to forestall the development of complications. However, the nurse is responsible for preparing the unit in which to receive the patient, protecting him from injury while he is unconscious, and utilizing nursing skills that will help to prevent complications. The unit and recovery bed will vary with the individual hospital's procedure. The bed should be clean and have adequate rubber protection. The room should be well aired but free from draughts. There should be sufficient light so the patient's color can be observed accurately. He should be handled gently. His position in bed will vary with his condition, the type of operating and the anesthesia. His position should be one, however, that definitely aims at preventing respiratory obstruction. The usual practice is to place the patient on his side in such a position as to encourage drainage of mucus and vomitus from his mouth. Care must be exercised that the tongue does not fall back into the throat because of muscular relaxation and thus obstruct the air passage.

As soon as the patient has been placed in bed, the time of his return, state of consciousness, and general appearance and condition should be noted. This can be done briefly by observing the color and condition of the skin, the quality and rate of the pulse and respiration, the blood pressure reading, and the condition of the dressing. These factors should be noted every fifteen to twenty minutes during the period that the patient remains unconscious.

The position of the patient during his convalescence will alter depending on his condition, type of operation, and direction of the attending physician. The present trend is toward early ambulation, and movements in bed are encouraged,

as are deep breathing exercises. These are precautionary measures against such ailments as phlebotrombosis and hypostatic pneumonia.

The same rule holds true regarding the administration of a diet and fluids; that is, it depends on the individual case and the surgeon's preference. Fluids should be given, however, in such quantities as to insure a urinary output of at least 1000 cc. daily.

The patient usually experiences a certain degree of postoperative discomfort after recovery from anesthesia, such as pain in the incision, headache, backache, nausea, and distention of the urinary bladder and bowel. The specific postoperative orders will vary with the preference of the attending doctor; however, the nurse should utilize every skill known to her to ensure the comfort of the patient. Analgesics should be administered as indicated. The nurse, however, should be on the alert for any evidence of toxicity and remember that restlessness may be the result of a distended bladder.

Careful nursing can reduce the patient's discomfort and speed his convalescing period. Remember, too, that instruction in health measures as indicated is important along with the bedside care of the patient. Every hospital nurse should realize her obligation of seeing that the patient is discharged in a state of mental and physical well-being that will enable him to resume his place in the community.

### UROLOGICAL NURSING

KATHRYN FOX, B.S., R.N.\*

The general principles of nursing care of urological patients are the same as with other patients, but certain special points in the care of urological cases deserve mention.

On admission it is a routine order that urinalysis be done because the working capacity of the kidneys must be known. Specimens are collected with the utmost care. Wide mouth bottles should be used so that the patients can void directly into them. If this is impossible, we should collect the urine in some clean container other than the bedpan. The common habit of collecting urinary specimens in bedpans or enamel or metal urinals is a very bad one, since it is impossible to be sure that they are absolutely clean. In the routine examination of males, a single, freshly voided specimen is usually regarded as sufficient. With females, it is advisable to use a catheter, thus avoiding possible admixture of vaginal secretions.

Careful labeling of urine specimens is of greatest importance; it should be noted whether it is

a catheterized or voided specimen. It is well also to mark upon the specimen requisition the hour at which it was voided.

Urine for cultures should be obtained with sterile precautions. In women this is usually done by means of catheterization. If the patient is a male, a catheterized specimen may be obtained in the same manner, although the specimen usually is obtained by voiding.

Gross examination of the urine may be a valuable diagnostic aid, but the data must be correlated with the findings of other examinations. It is the nurse's responsibility to record the gross observation.

Blood in the urine is exceedingly important. An interesting fact about hematuria is that pain is generally absent. Pain may occur if the blood clots and forms an obstruction. The origin of the blood may be suggested by the character and the color of the urine.

For urinalysis one should have at least 100 cc. of urine.

In kidney tests, nurses play an important role, for any mistakes in making these collections will cause the results of the tests to be wrong. Every hospital and doctor generally has his own procedures for kidney tests, so first check with the nurse in charge. Do not rely upon past knowledge. Most important method of examination is intravenous urography: cystoscope and retrograde. It is not necessary to go into detail here, but there are a few points where the nursing staff can be helpful. If the ureters are to be catheterized, the patient should be given plenty of fluids to drink so there will be copious secretion of urine during examination. If retrograde pyelogram or other x-rays are to be taken, laxatives and enemas are necessary preparation and in addition, you still force fluids. Also urge fluids after the procedure.

We are fortunate that emergency operations are comparatively rare, because the working capacity of the kidneys must be known before an operation is attempted. When a certain amount of fluids is ordered, three-fourths of the allowance is usually given during the day and one-fourth during the night. It should be calculated in glasses per hour and considered as a medication. Be there and offer the necessary fluids, as it is most uncomfortable to the patient to ingest such a large volume of liquid, and he has a tendency to neglect the fluid intake.

Another important duty of the nurse is to keep a careful record of intake and output. The fluid intake includes all fluids taken into body, regardless of method. Accurate measurement of output

\* Instructor, The Queen's Hospital School of Nursing.



calls for careful attention. Instruct the patient to always void into a receptacle so it can be saved and measured. Quite frequently the doctor will want to know the amount voided at each voiding.

An essential phase of postoperative urologic nursing is keeping the dressings dry.

Position following a nephrectomy is important. The patient should lie upon his back or operative side so the weight of the other organs will help obliterate the cavity and promote drainage.

Catheterization always entails a danger of infection. Never catheterize without an order.

If a Foley catheter is inserted, it must be kept in place. Connect it to a piece of rubber tubing. The tubing should be neither too soft, so that it may easily become kinked in bed, nor too hard, so that it may be too difficult to handle. Rubber tubing should be pinned to bed linen so the weight of the tubing does not drag on the catheter. Remember that dirty, coated collecting bottles and connecting tubes are signs of poor nursing. Do not drain catheters into urinals, as this keeps the perineum wet and invites infection. Catheters should be changed every four to seven days, unless otherwise ordered. Report to the nurse in charge if a catheter becomes obstructed. Nurses should check their patients frequently, check tubing often, and note the drainage.

Tidal drainage is a comparative new procedure. The purpose of tidal drainage is alternately to fill and to empty the bladder. It imitates the natural physiology of the bladder. The bladder is filled with fluid from an irrigating bottle and urine from the kidneys until the pressure within it forces the fluid up into the tube. Siphonage begins and continues until the bladder starts to fill again. At this time there is no residual urine in the bladder.

Tidal drainage prevents infection, since antiseptic solution is almost continuously in contact with the bladder walls and since it will not allow the progressive contracture of the bladder which occurs with the indwelling catheter. It aids in maintaining the normal contractibility of the bladder.

The whole picture of urological nursing is one of careful observation, minute attention to technique, avoidance of infection, and competent nursing.

#### CEREBRAL PALSY FLORENCE AKATSUKA\*

With a gleam of hope and trust in their eyes, without any fervor of mischief in their faces which belong in the faces of youth, the children arrived

at the Cerebral Palsy Center in Kapahulu at eight o'clock that morning.

To fulfill the dreams of these children as nearly as possible was the goal of the physical therapist, the occupational therapist, and the speech therapist who greeted them.

There were eight children present that morning, all with average or better than average intelligence. While some played with special-built playthings, others worked with the specialists.

A spastic type child was put through his daily exercise which consisted of relaxing his muscles and putting his arm on his lap. With the help of sand bags he finally laid it there, but the slightest motion brought it right up again in a tense position above his head.

In another room a little girl was learning the art of sucking through a straw. This was a form of speech training. She was unable to say even the simple words of "Dada" and "Mama."

One youngster who was working with the occupational therapist was learning to hold a pencil in her hands. She was the athetoid type of child who had no muscle control. Her every effort was heart-rendering. She was trying so very hard.

As I played with the children, I noticed that all their playthings were constructed for convenience to them. The little chairs were extra heavy and their table was built in such a way that they could lock themselves in an opening to prevent falling.

The children were taught how to fall to prevent injury; falls were frequent that morning but not injurious. Most of them could walk with braces and a few without them.

We left the Center when rest time came at ten o'clock that morning. The observation was very educational and interesting.

#### Sultan's Clinic

At the Sultan's Clinic the children were more advanced physically than at Cerebral Palsy. Some of them were almost ready to be placed in specialized schools such as the Kapahulu School for the handicapped and the Puuhale School for physically disabled children, on Nimitz Highway.

Each day the occupational therapist worked with a child while the others played. To get her patient interested in her exercises, she gave her a piece of candy to hold in her hands. If the patient wanted to suck on the candy she had to raise her arms. In so doing she had her daily exercise of loosening her arm muscles.

In one end of the hut there was a room almost surrounded by mirrors. Here is where the physical

\* Student, Practical Nurse Training School.

therapist worked. She laid her patient on a table and exercised the legs of the child. The boy was able to lift his leg and leave it thus in that position. She explained that when he first came to the Clinic, he was unable to do so.

The children had half an hour every day for singing. As they sang they went through the motions of the song. One of the workers explained that this was one of the best ways to give the children speech and physical exercises.

Upon observing the children, I found three of them to be exceptionally interesting. One was a blind girl of about six, the other a deaf girl, and the third, armless.

The case history of the blind girl was almost tragic. Her parents did nothing for her until she was brought to the Clinic. She went there in diapers, was unable to walk or talk and was a regular baby. Doctors classified her as feeble minded and made arrangements to send her to Waimano Home. Sultan's decided to give her a try; now several weeks later, she is able to walk, talk, and is much more cheerful.

The little deaf girl was unable to understand why the other children did what they did. During singing time, her look of bewilderment was pathetic. She tried so hard to follow through.

The absence of two arms made little or no difference to the girl who used her feet so well. She did with her legs everything we do with our arms. She even went so far as sucking her toes while she slept. You simply had to smile when you watched her and admire her for her bravery and courage.

All of the children seemed very happy at Sultan's and I'm sure that it will not be long before we see them as useful citizens of the community.

The Sultan's Clinic is partially supported by the Easter Seals Fund and all needy children, rich or poor are accepted for treatment and care.

#### MISS CARLUCCI WEDS DR. STEMPEL

In a lovely garden setting Miss Angela Carlucci became the bride of Dr. Daniel Stempel on June 15, 1951. The ceremony was performed by Judge Clifton Tracy.

Mrs. Stempel, a graduate of Yale School of Nursing, has been Director of Nursing Education at Leahi Hospital for the past year, and the efficient editor of the INTER-ISLAND NURSES' BULLETIN. Dr. Stempel was graduated from Harvard University, and is beginning a year's leave of absence from his post as Professor of English Literature at the University of Hawaii. He is returning to Harvard where he will teach English Literature during the ensuing school year, and Mrs. Stempel will join him September first. They expect to return to Honolulu upon the expiration of Dr. Stempel's leave.

#### MAHALO

Mahalo to my Colleagues and the many persons who contributed their time and efforts toward making my year of editorship a pleasant and stimulating experience.

I regret that I must leave the Islands even though it is only for one year, but Dr. Stempel and I will return.

My best wishes and congratulations to the succeeding Editor—may she enjoy, in preparing the forthcoming issues, the fun I have had in preparing those of the past year.

Aloha oe

ANGELA C. STEMPEL

**Whenever you change your address, please be sure to notify**

**Mrs. Grace Page, Office Secretary  
Nurses' Association, Territory of Hawaii  
Mabel Smyth Building  
510 South Beretania Street  
Honolulu, Hawaii.  
Phone: 6-8630**

**Magazines sent to your former address cannot be forwarded by the Post-office.**

**Your subscription will be temporarily suspended if your BULLETIN is returned to us because of a wrong address, and you will be notified by post card.**





**NO FORTIFICATION NEEDED**

The vitamin content of S-M-A is well in excess of the requirements of the normal infant, and is more constant than the vitamin content of breast milk.

## *A Complete, Protective Infant Food . . .*

**S-M-A**, diluted and ready to feed, provides in each quart the following proportions of the minimum daily requirements for infants.

<b>VITAMIN A</b> 5,000 U.S.P. units	333%
<b>VITAMIN D</b> 800 U.S.P. units	200%
<b>THIAMINE</b> 0.67 mg.	250%
<b>RIBOFLAVIN</b> 1 mg.	200%
<b>VITAMIN C</b> 50 mg.	500%
<b>NIACINAMIDE</b> 5 mg.	—

Ready-to-feed S-M-A is the most complete formula for infants. Its protective vitamins are administered in the most satisfactory way—right in the food and in each feeding. No danger of forgetting, no extra burden for busy mothers.

No infant food is more like breast milk than S-M-A—in content of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physical properties.

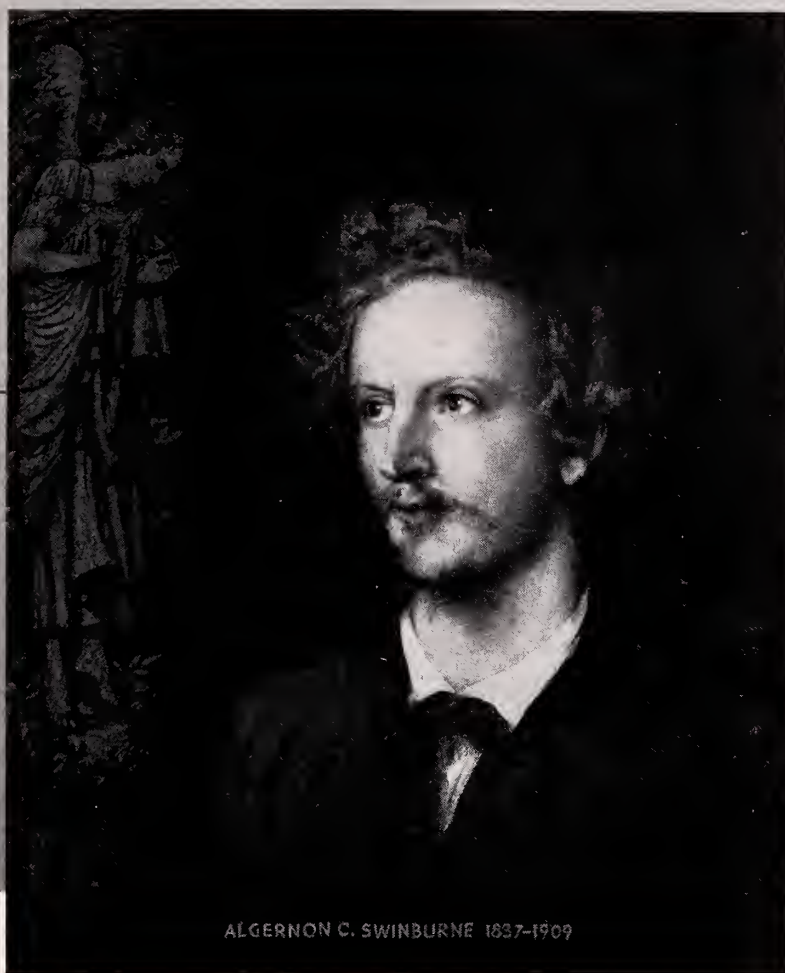
**S-M-A CONCENTRATED LIQUID**—cans of 13 fl. oz.

**S-M-A POWDER**—1 lb. cans



**S-M-A<sup>®</sup>**  
*vitamin C added*  
*builds husky babies*

Wyeth Incorporated, Philadelphia 2, Pa.



ALGERNON C. SWINBURNE 1837-1909

★ *Epileptic Men of Genius* ★

The famous English poet, Algernon Charles Swinburne, who began to show signs of epilepsy at the age of 25, is a prominent example that despite epilepsy a man may develop to true greatness.

Comparative studies have shown that in some cases better control of grand mal as well as petit mal seizures can be obtained with Mebaral than with corresponding doses of other antiepileptic drugs. Mebaral produces tranquillity with little or no drowsiness. It is particularly desirable not only in epilepsy but also in the management of anxiety states and other neuroses. The fact that Mebaral is almost tasteless simplifies its administration to children. Average dose for children  $\frac{1}{2}$  to 3 grains, adults 3 to 6 grains daily. Tablets  $\frac{1}{2}$ ,  $1\frac{1}{2}$  and 3 grains.

**MEBARAL<sup>®</sup>**  
Brand of Mephobarbital

*Winthrop-Stearns* INC. • NEW YORK 13, N. Y. WINDSOR, ONT.

Mebaral, trademark reg. U. S. & Canada



## OUR GROUP INSURANCE PLAN

When a professional man is disabled his earning power suffers severely and his expenses are greatly increased. He needs disability insurance that he can depend on.

By sponsoring a group plan, with a high percentage of our membership enrolled, we get more liberal underwriting. Many of our members would be unable to buy good disability insurance otherwise. In addition, we get broader coverage against all disabilities, without the exclusions for pre-existing causes, foreign travel, many specific diseases and conditions, etc., which are in individual contracts. Furthermore, the company cannot cancel individual policies, and we get all this at wholesale group rates—at a very great savings in cost.

That is why hundreds of professional organizations all over the country have found it wise to sponsor Group Plans for their members.

Under these circumstances it is difficult to imagine why any eligible member wouldn't enroll for all he can get of this superior protection as the foundation of his program of disability insurance.

Carry as many additional policies as you wish, but don't pass up this **REAL VALUE**. You can count on this protection when you need it. Ask the Medical Society office for an application blank TODAY!

## Head Pain as a Diagnostic Lead

Frequently the presence of head pain is overlooked. The physician learns of it only if he has made an effort to elicit the information. Since the etiology of the pain is the basis of rational management, the patient should be warned against taking medication before diagnosis is made.

Friedman<sup>1</sup> deplores the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache—its character, laterality, frequency and intensity.<sup>2</sup>

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic: analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain unrelated to b.p. level; Dihydroergotamine relieves pain.	General hypertension therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g.i. upset during headache.	To abort attack: oral ergotamine plus caffeine. General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,<sup>3</sup> and Friedman, A. P.<sup>4</sup>

Cecil<sup>5</sup> ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

1) *Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.*

2) *Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.<sup>1,6</sup> The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.*

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 54:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563; Saunders Co., Phila. 5. Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

**Sandoz Pharmaceuticals**

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, NEW YORK



**stress**

Stress, common to severe infections, in surgery and burns, increases demands upon adrenal cortical function. When adrenal cortical function is hard-pressed and recovery threatened or convalescence impeded by inadequacy of output

**R Upjohn Adrenal Cortex Extract**

*by subcutaneous, intramuscular or intravenous injection.*



Pioneering research by Upjohn investigators in adrenal physiology has contributed to the availability, to the potency and to the standardization of extracts providing *all* of the natural cortical hormones.

Each cc. of Upjohn Adrenal Cortex Extract contains the biological activity equivalent of 0.1 mg. of 17-hydroxycorticosterone, as standardized by the Rat Liver-Glycogen Deposition test. Alcohol content 10%.

**Upjohn**

**Research**

*for Medicine... Produced with care... Designed for health*

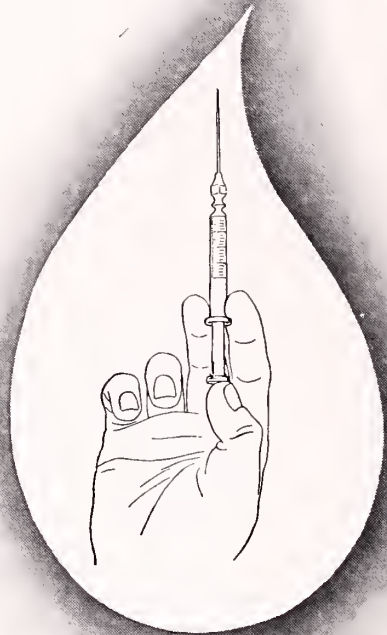
THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN



# Dihydrostreptomycin Sulfate

## a Drug of Choice

## for Physician and Patient



Extremely well tolerated and rarely causing irritation on injection, Dihydrostreptomycin Sulfate has become a most widely accepted streptomycin preparation.

**Comparative studies by leading clinicians confirm that DIHYDROSTREPTOMYCIN SULFATE IS —**

**as effective as streptomycin 2, 9, 13-15**

**less toxic for the vestibular apparatus 1-15**

**minimizes pain and swelling at the site of injection 6; 10**

**may be used even in patients showing allergic**

**response to streptomycin 2, 9, 10, 11**

**Extensive experimental studies 6, 9, 16-18**

**proved CRYSTALLINE DIHYDROSTREPTOMYCIN SULFATE MERCK**

**less toxic for the vestibular system.**

### BIBLIOGRAPHY

(1) Tompsett, R., and McDermott, W., *Am. J. Med.* 7: 371-381, Sept. 1949. (2) Tompsett, R., *Ann. Otol., Rhin. & Laryng.* 57: 181, March 1948. (3) Sweany, H. C., *Dis. Chest* 15: 631-656, June 1949. (4) Lincoln, S., *Science News Letter* 55: 307, May 14, 1949. (5) Semans, J. H., *J. M. A. Georgia* 38: 477-480, Nov. 1949. (6) Domon, C. M., Kilbourne, P. C., and King, E. Q., *Amer. Rev. Tuberc.* 60: 564, 575, Nov. 1949. (7) Nagley, M. M., *Brit. M. J.* 1: 248, Jan. 28, 1950 (in correspondence). (8) Committee on Medical Research and Therapy, American Trudeau Society, *Am. Rev. Tuberc.* 61: 436-440, March 1950. (9) Carr, D. T., Hinshaw, H. C., Pfuetze, K. H., and

Brown, H. A., *Dis. Chest* 16: 801-821, Dec. 1949. (10) Odell, J. M., *Dis. Chest* 16: 818, Dec. 1949. (11) (Editorial) *New England J. Med.* 240: 736, May 5, 1949. (12) Keefer, C. S., *Ann. Int. Med.* 33: 582-589, Sept. 1950. (13) Marsh, D. F., *W. Va. Med. J.* 45: 280-284, Oct. 1949. (14) Johnson, H. M., *J. Invest. Dermat.* 15: 61-66, July 1950. (15) Hinshaw, H. C., Personal communication. (16) Lincoln, N. S., Horton, R., Stokes, A. M., Monroe, J., and Riggins, H. M., *Am. Rev. Tuberc.* 62: 572-581, Dec. 1950. (17) Carr, D. T., Brown, H. A., Hogson, C. H., and Heilman, F. R., *J. A. M. A.* 143: 1223-1225, Aug. 5, 1950. (18) Jacoby, A., Goldberg, W., Sobel, N., and Rosenthal, T., *Am. J. Syph., Gonorr. & Ven. Dis.* 34: 185-186, March 1950.

*Supplied By Merck In The Purest Form Available—*

## CRYSTALLINE DIHYDROSTREPTOMYCIN SULFATE MERCK

Crystalline Dihydrostreptomycin Sulfate Merck is supplied in convenient 1 Gm. and 5 Gm. vials.



**MERCK & CO., INC.**

*Manufacturing Chemists*

RAHWAY, NEW JERSEY

*In Canada: MERCK & CO. Limited—Montreal*

# Both High In Food Value, Low In Fat

The slight differences in these two healthful dairy foods will be of interest to doctors who must recommend nutritive but low-calorie diets to patients with obesity or digestive difficulties.



recommend

DAIRYMEN'S

**yami**  
yogurt  
TRADE MARK REG.

To aid digestion and increase  
calcium and other mineral  
content in the diet

recommend

DAIRYMEN'S *Creamed*

**COTTAGE CHEESE**

To increase protein and other  
milk nutrients in the  
low-calorie diet

The easy and quick digestibility is the outstanding characteristic of Yami Yogurt, which actually aids in the digestion of other foods, as well. It is interesting to note that, because of the high content of lactic acid (1 to 3%), Yami Yogurt is digested and assimilated in the proportion of approximately 100% after three hours of digestion. (Whole milk is digested in the proportion of 44% after three hours.) Yami Yogurt can be enjoyed daily in large quantities by adults and children in whom milk produces dyspeptic symptoms, without causing the least discomfort. Its curd tension is zero. The 1/2 pound carton contains only 170 calories.

Dairymen's Cottage Cheese is richer in butter-fat than Yami Yogurt. Cream is added for just that purpose—to give it the richness of flavor which most people like in cottage cheese and to maintain a good Vitamin A balance. But it is lower in butter-fat content than whole milk, and more concentrated in its nutrients. One small "cottage" (1/2 lb. carton) contains most of the protein, calcium, phosphorous, iron and vitamins found in approximately 1 1/2 quarts of milk. Yet the 1/2 lb. carton contains only 240 calories.

## DAIRYMEN'S RICH MILK AND DAIRY PRODUCTS

A Full Line of Nature's Finest Foods for Every Need

# Dairymen's

ASSOCIATION, LTD.

*A Division of Creameries of America, Inc.*



**"Nowhere in medicine are more dramatic therapeutic effects obtained than those which follow estrogen therapy in the girl who has failed to develop sexually. A daily dose of 2.5 to 3.75 mg. of 'Premarin' given in a cyclic fashion for several months may bring about striking adolescent changes in these individuals."**\*

\*  
Hamblen, E. C.: Some Aspects  
of Sex Endocrinology  
in General Practice,  
North Carolina M. J.  
7:533 (Oct.) 1946.

**"PREMARIN"**

*Estrogenic  
Substances  
(water-soluble)  
also known as  
Conjugated  
Estrogens  
(equine).*



"Premarin"—a naturally occurring conjugated estrogen—long a choice of physicians treating the climacteric—has been earning further clinical acclaim as replacement therapy in hypogenitalism.

In the treatment of hypogenitalism, the aim of "Premarin" therapy is to develop the reproductive and accessory sex organs to a state compatible with normal function.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

"Premarin" contains estrone sulfate plus the sulfates of equilin, equilenin,  $\beta$ -estradiol and  $\beta$ -dihydroequilenin. Other  $\alpha$ - and  $\beta$ -estrogenic "diols" are also present in varying amounts as water-soluble conjugates.



**Ayerst, McKenna & Harrison Limited**  
22 East 40th Street, New York 16, New York

5005 R

*Effective against many  
bacterial and rickettsial infections, as well as  
certain protozoal and large viral diseases.*

# AUREOMYCIN

Hydrochloride Crystalline

*Lederle*

The Ophthalmologist now possesses in aureomycin a therapeutic agent effective against many infections of the eye, whether caused by bacteria or by large viruses. A half per cent solution is nonirritant to the conjunctiva, so that aureomycin may be given locally, systemically, or in both ways. It has been found of value in most types of conjunctivitis, as well as in dendritic keratitis and uveitis; and is of importance in the treatment of the acute stage of trachoma. Aureomycin is invaluable in both operative and nonoperative ophthalmology.



#### *Packages*

*Capsules:* Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.  
*Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION

*AMERICAN Cyanamid COMPANY*

30 Rockefeller Plaza, New York 20, N. Y.





# BELIEVE IN YOURSELF!

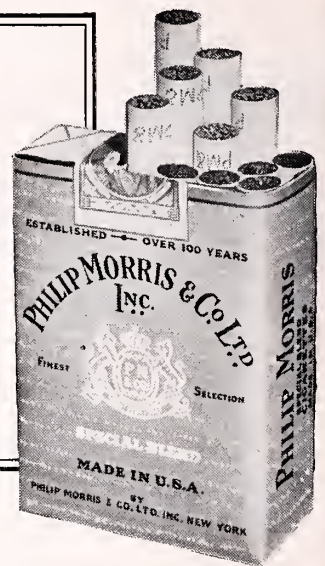
Doctor, you probably have read a great deal of cigarette advertising with all sorts of claims.

So we suggest: make this simple test...

Take a PHILIP MORRIS—and *any* other cigarette. Then,

1. Light up either one. Take a puff — don't inhale — and s-l-o-w-l-y let the smoke come through your nose.

2. Now do exactly the same thing with the other cigarette.



*Then, Doctor, BELIEVE IN YOURSELF!*

## PHILIP MORRIS

Philip Morris & Co. Ltd., Inc.  
100 Park Avenue, New York 17, N. Y.

## GROWING INDUSTRIES FOR A GROWING COMMUNITY

# FLOWERS...

### an industry blossoms out

*Hawaii today is working to build new industries to aid in expanding the islands' economy. This series of advertisements calls attention to these forward steps . . . and to their promise for Hawaii's future.*

The representatives of Hawaii's most colorful big business—flowers and foliage—have taken their first big step toward industry-wide coordination. They have met in a Floral Clinic, aimed at finding new ways to make the returns from their gardens grow.

These men and women—florists, growers, shippers and lei sellers—set themselves a major objective: to supply, from Hawaii, five per cent of the nation's yearly purchases of flowers. Today the industry supplies just one per cent, but it is a big contribution to the islands' economy. Last year it added up to more than \$3,000,000.

It is yet a young industry. Though floral trade was born centuries ago with the gift of the first leafy lei, it became big business only with shipments to the mainland, growing with tourist trade and the development of air transportation. Today more than 3,000 growers sell floral products through commercial channels.

It has been a quick climb but not an easy one. Insects and plant diseases have hampered production; difficulties in packing have plagued the shippers. A present problem is lack of coordinated marketing.

But advances are being made in all three fields, and Hawaii's flowers have natural market advantages. To these assets, Hawaii is adding the ingenuity of its plant scientists, the rich background of its own traditions, the power of a united industry. It is finding, in its own backyard, a growing island industry.



#### FREE BOOKLET

A brief survey of Hawaii's expanding floral trade has been published as a guide to a young industry and an illustration of the islands' opportunity for the future. For a free copy, write The Hawaiian Electric Co., Ltd., P. O. Box 2750, Honolulu.



**THE HAWAIIAN ELECTRIC CO., LTD.**

*The development of new industries requires individual initiative and community cooperation. In keeping with this progressive spirit of growth, The Hawaiian Electric Co., Ltd., is constantly planning ahead, expanding its own facilities and equipment . . . building today for tomorrow's needs.*



**BUILDING TODAY for Tomorrow's Needs**

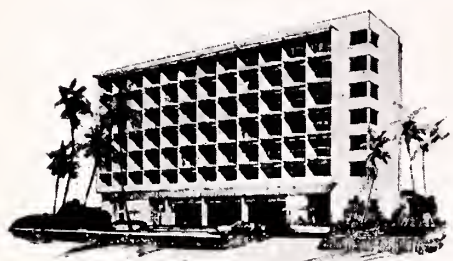


THE

# SurfRider

A heritage from  
Old Hawaii  
becomes a symbol of  
modern hospitality

In January Waikiki's newest hotel, the \$1,250,000 seven-story SurfRider, will open its doors. For residents and visitors alike it is an important landmark. Using local supplies and services wherever possible, it has created new jobs at home. Most important, the SurfRider means more travel trade income for all the islands. As the surfrider is a proud symbol of Hawaii's outdoor pastimes, with this hotel Matson hopes to make the name an equally proud symbol of island hospitality.



## THE SURFRIDER

☆☆☆☆☆☆☆☆☆☆☆☆☆☆☆☆

MATSON LINES



## INDEX TO ADVERTISERS

	PAGE		PAGE
Abbott Laboratories.....	8	Merck & Co., Inc.....	56
Ayerst, McKenna & Harrison, Ltd.....	58	Parke, Davis & Company.....	2, 3
Borden Company.....	16	Pet Milk Company.....	13
Brainard & Black, Ltd.....	54	Pfizer & Co., Inc.....	4, 5
Carnation Company.....	9	Philip Morris & Co., Ltd., Inc.....	60
Dairymen's Association, Ltd.....	57	Sandoz Pharmaceuticals.....	10, 54
Don Baxter, Inc.....	63	Schering Corporation.....	7
Eli Lilly & Company.....	1, Insert	Schuman Carriage Company.....	43
Ethicon Sutures Laboratories, Inc.....	Insert	Searle & Co.....	44
Hawaiian Electric Co.....	61	Squibb & Sons.....	12
Home Insurance Co.....	10	Upjohn.....	55
Hotel Import Co.....	42	Wadsworth's.....	41
Lederle Laboratories, Inc.....	59	Wander Company.....	11
Matson Lines.....	62	Winthrop-Stearns, Inc.....	53
McArthur & Summers.....	14	Wyeth, Inc.....	6, 52
Mead Johnson & Co.....	64		

# *Intravenous* **PROCAINE**

*The least toxic of all local anesthetics*

No other local anesthetic has the extensive clinical background in intravenous use.

Therapeutically versatile...  
Clinically effective...Widely used

*Baxter PROCAINE Solutions*  
for the relief of pain

Because of its many uses,  
intravenous procaine  
has become a dependable  
therapeutic procedure  
of established value.



**BAXTER**

**PROCAINE SOLUTIONS**

are **DILUTE** solutions...there  
is **SAFETY** in dilution

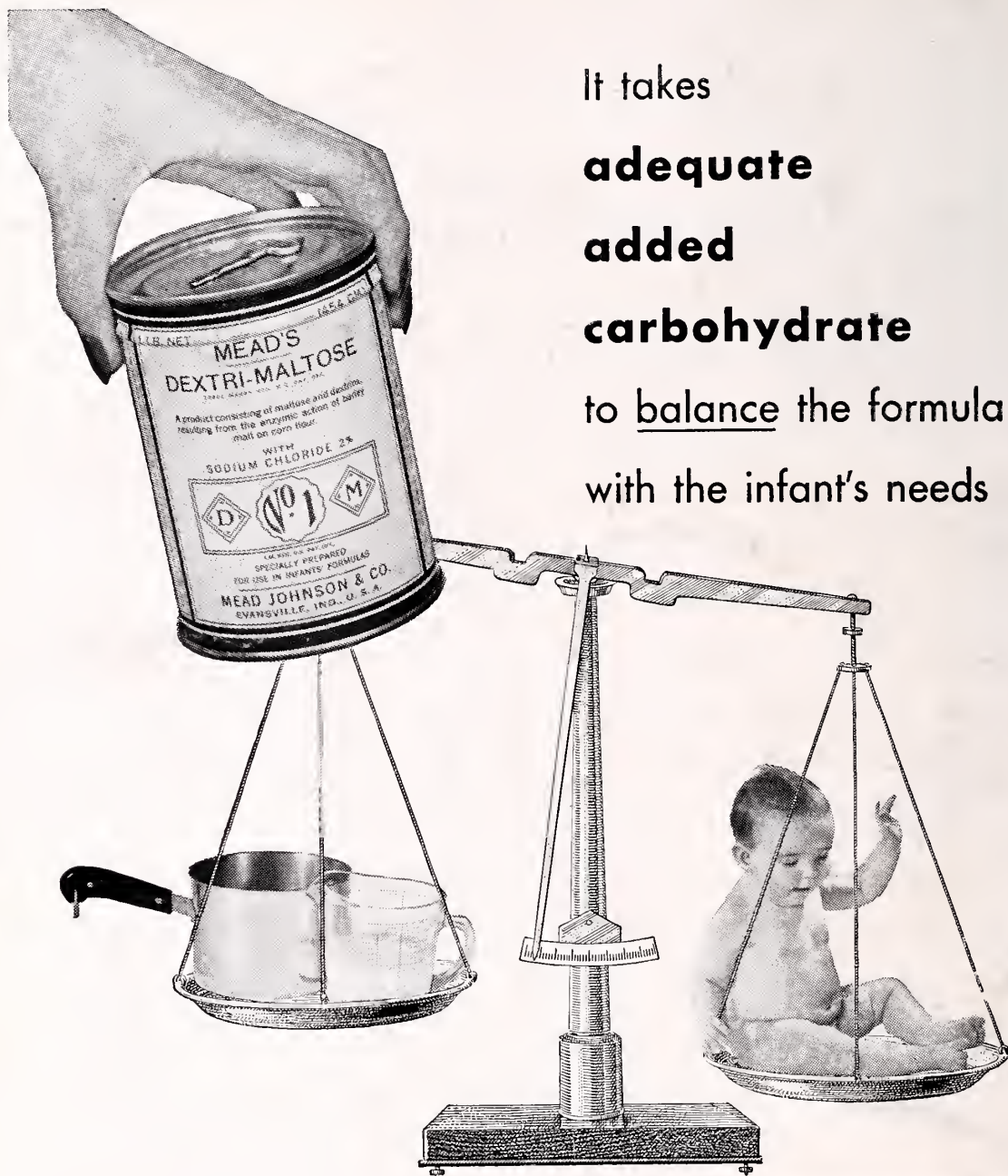
**DON BAXTER, INC.** • RESEARCH AND PRODUCTION LABORATORIES • GLENDALE 1, CALIFORNIA

*Territorial Distributors:*

**CROCKETT SALES COMPANY**

P. O. Box 3017, Honolulu, T. H., Phone 6-8992





It takes  
**adequate**  
**added**  
**carbohydrate**  
 to balance the formula  
 with the infant's needs

Added carbohydrate is a necessity for a well balanced formula. In *adequate* amounts, carbohydrate:

1. Spares protein for essential tissue building functions.
2. Permits proper metabolism of fat.
3. Promotes optimum weight gain.
4. Encourages normal water balance.

Pediatric authorities recommend a caloric distribution of about 15% from protein, 35% from fat, 50% from carbohydrate. For forty years, cow's milk and Dextri-Maltose® formulas with this approximate caloric distribution have been used with success.

These formulas often consist of  $\frac{1}{3}$  evaporated milk,  $\frac{2}{3}$  water and 5% added Dextri-Maltose—1 level tablespoon Dextri-Maltose to 5 ounces of formula.



# HAWAII MEDICAL JOURNAL

## and INTER-ISLAND NURSES' BULLETIN

NOVEMBER-DECEMBER, 1951

NUMBER

### ACCIDENTAL POISONING IN CHILDREN

L. T. Chun..... 83

### SOME COMMON ARRHYTHMIAS AND THEIR TREATMENT

F. Bernard Schultz..... 88

### AN EPIDEMIC OF CONJUNCTIVITIS IN HAWAII

William John Holmes..... 94

FEATURES ..... 95

INTER-ISLAND NURSES' BULLETIN..... 107

### REMEMBER THIS TERM?

*si non valeat*



No doubt you would if you had practiced in 1876,  
when Eli Lilly and Company had just begun  
—and the first incandescent light was still four years away.

Then, the prescription term *si non valeat*, meaning *if it does not avail*,  
followed by an alternative recommendation,  
was appropriate to most of that era's "remedies." Since then,  
medical and pharmaceutical progress  
has developed the certainty of effect  
which you can expect—when you specify Lilly.



*Lilly*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.



# Rapid Clinical Response



**PARKE, DAVI**

*with*  
**Chloromycetin<sup>®</sup>**

**MEANS EARLY RETURN TO NORMAL ACTIVITIES**

Continuity of treatment with well-tolerated CHLOROMYCETIN produces a rapid clinical response in a wide variety of bacterial, viral, and rickettsial diseases. Convalescence is smooth, and an early return of the patient to his normal activities may be anticipated.

CHLOROMYCETIN (chloramphenicol, Parke-Davis)  
*is supplied in the following forms:*

CHLOROMYCETIN Kapseals,<sup>®</sup> 250 mg., bottles of 16 and 100.

CHLOROMYCETIN Capsules, 100 mg., bottles of 25 and 100.

CHLOROMYCETIN Capsules, 50 mg., bottles of 25 and 100.

CHLOROMYCETIN Ophthalmic Ointment, 1%,  $\frac{1}{8}$  ounce collapsible tubes.

CHLOROMYCETIN Ophthalmic, 25 mg. dry powder for solution,  
individual vials with droppers.

**COMPANY**







Case report\*—Jimmy and Johnny E., twins. Birth one month premature—"shadowed" by placenta previa and delivery by section. The twins are S-M-A babies from birth. The mother's condition was so poor that her own survival was in doubt. Therefore, there was little opportunity to do more than prepare the S-M-A formula. The babies received no supplementary vitamins. Weight at 8 months of age, 22 pounds (one underwent surgery for hernia at the age of 6 weeks).

*\*Volunteered by the proud mother, supported by data supplied by attending physician (name on request).*

# S-M-A<sup>®</sup>

with Vitamin C added

## builds husky babies



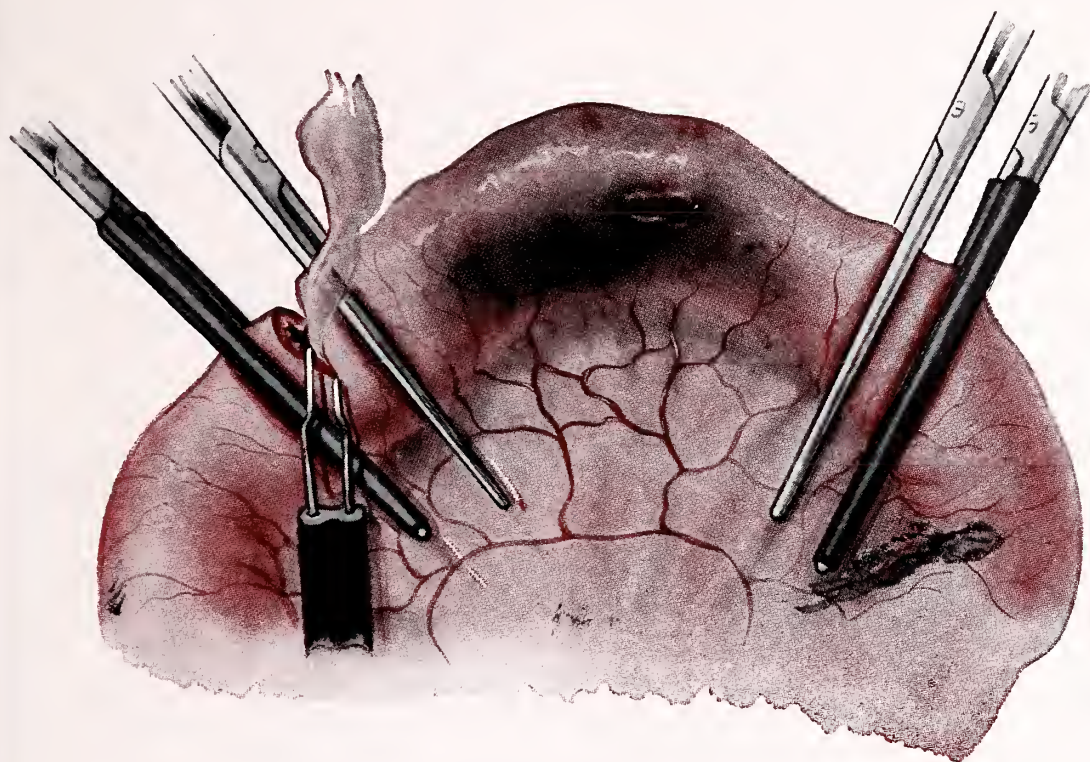
*Supplied:*

S-M-A Concentrated Liquid—cans of 13 fl. oz.

S-M-A Powder—cans of 1 lb.



*Wyeth* Incorporated • Philadelphia 2, Pa.



*in bowel sterilization:*

"Terramycin...had a pronounced effect on the bacterial flora of the healthy and diseased bowel of man...Its effectiveness as an antimicrobial agent in the preparation of patients for surgical measures on the bowel appeared unexcelled."

*DiCaprio, J. M., and Rantz, L. A.: Arch. Int. Med. 86:649 (Nov.) 1950.*

CRYSTALLINE TERRAMYCIN HYDROCHLORIDE

*available*

*Capsules, Elixir, Oral Drops, Intravenous, Ophthalmic Ointment, Ophthalmic Solution.*

ANTIBIOTIC DIVISION



CHAS. PFIZER & CO., INC., Brooklyn 6, N. Y.



The "estrogen  
preferred by us is  
'Premarin,' a mixture  
of conjugated estrogens,  
the principal one  
of which is  
estrone sulfate."

Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

"PREMARIN"®

In treating the menopausal syndrome with "Premarin," Perloff\* reports that "Ninety-five and eight tenths per cent of patients treated with 3.75 mg. or less daily obtained complete relief of symptoms"; also, "General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Thus, the sense of "well-being" usually imparted represents a "plus" in "Premarin" therapy which not only gratifies the patient but is conducive to a highly satisfactory patient-doctor relationship.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).



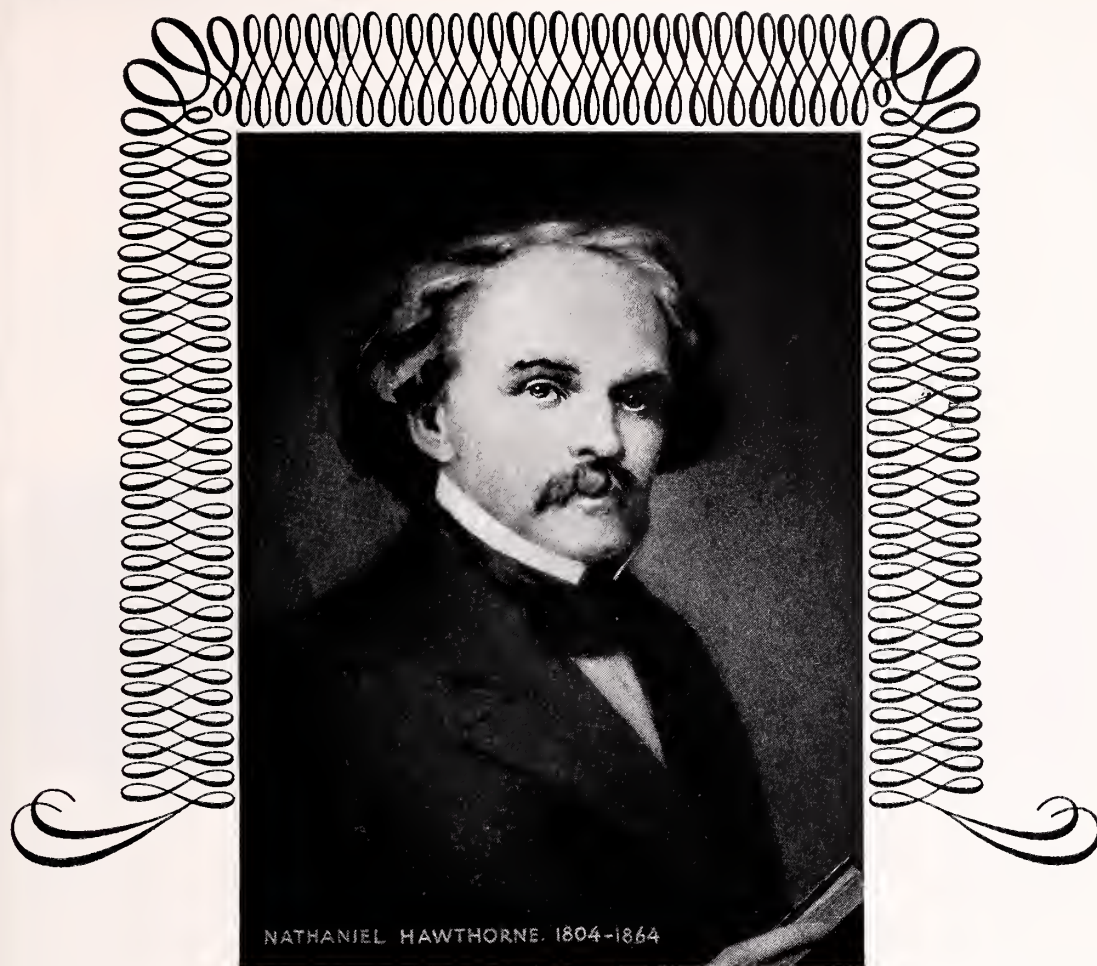
\*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

"Premarin" contains estrone sulfate plus the sulfates of equilin, equilenin,  $\beta$ -estradiol, and  $\beta$ -dihydroequilenin. Other  $\alpha$ - and  $\beta$ -estrogenic "diols" are also present in varying amounts as water-soluble conjugates.

*Estrogenic Substances (water-soluble) also known as Conjugated Estrogens (equine)*

Ayerst, McKenna & Harrison Limited  
22 East 40th Street, New York 16, N. Y.





## *Psychoneurotics of Genius*

Hawthorne, distinguished American novelist, is said to have been afflicted with a psychoneurosis from early childhood. His quiet life, wholly detached from the major activities of the times, was largely given over to brooding solitude.

The majority of psychoneurotics have no serious mental illness, but display merely an emotional imbalance which often can be greatly improved by appropriate psychotherapeutic and sedative management. In the treatment of psychoneurosis, particularly agitated, depressed and anxiety states, Mebaral is especially useful when tranquillity with minimal hypnotic action is desired. Sedative dose: Adults, from 32 mg. to 0.1 Gm. ( $\frac{1}{2}$  to  $1\frac{1}{2}$  grains) three or four times daily. Children, from 16 to 32 mg. ( $\frac{1}{4}$  to  $\frac{1}{2}$  grain) three or four times daily. Supplied in tablets of 32 mg., 0.1 Gm. and 0.2 Gm.

# MEBARAL<sup>®</sup>

*Brand of Mephobarbital*

**Tasteless SEDATIVE AND ANTIEPILEPTIC**  
Little or No Drowsiness

**WINTHROP-STEARN'S INC. • NEW YORK 18, N. Y. • WINDSOR, ONT.**

Mebaral, trademark reg. U. S. & Canada



# Cortone®

**most effective and practical therapy  
in Rheumatoid Arthritis**



**I**NCREASING supplies of CORTONE\* now offer many physicians their first opportunity to prescribe this dramatically effective hormone.

Extensive evidence based on three years' clinical experience has shown that CORTONE controls both objective and subjective manifestations of rheumatoid arthritis in virtually all cases; in many of these patients, CORTONE has been used for prolonged periods of time.

It is reassuring to note also that the administration of CORTONE does not necessitate any measures that are not readily available to the physician in everyday practice. The use of sim-

ple laboratory tests (sedimentation rate, urinalysis, blood count, blood pressure, and recordings of weight), individualized adjustment of dosage, and careful clinical observation will permit most patients to benefit materially . . . without fear of undesired effects.

## **CORTONE PRODUCT FORMS:**

**ORAL**—Cortone Acetate Tablets, 25 mg. each, bottles of 40 tablets.

**PARENTERAL**—Cortone Acetate, Saline Suspension for injection, vials of 20 cc., each cc. containing 25 mg.

\*CORTONE is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.



**MERCK & CO., INC.**

*Manufacturing Chemists*

RAHWAY, NEW JERSEY

In Canada: MERCK & CO. Limited—Montreal

*Literature on Request*

**Cortone®**  
ACETATE  
(CORTISONE Acetate Merck)



# The Importance of PREVENTING BORDERLINE NUTRITIONAL STATES IN CHILDREN

IN recent years increasing interest has been focused on the relationship between nutrition and the physical, mental and emotional development of children. It is now well recognized that listlessness and apathy in the child frequently may be nothing other than manifestations of a borderline nutritional state resulting from faulty food selection and inadequate consumption. Moreover, such sequelae of faulty nutrition often respond dramatically to improved food habits.\*

For preventing borderline nutritional states in children due to food whims, poor choice of foods, or lack of interest in eating, Ovaltine in

milk enjoys long-established usefulness. Its rich content of biologically complete protein, vitamins and minerals can supplement even grossly deficient diets to optimal nutrition. The delicious flavor of Ovaltine invites its acceptance and lends interest to eating when the appetite lags. Children particularly like Chocolate Flavored Ovaltine.

Three servings of Ovaltine in milk furnish the supplementary amounts of nutrients shown in the appended table.

\*Baumgartner, L.: Wider Horizons for Children; The Mid-century White House Conference and Children's Nutrition, J. Am. Dietet. A. 27:281 (Apr.) 1951.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

## Ovaltine

Three servings of Ovaltine, each made of 1/2 oz. of Ovaltine and 8 oz. of whole milk,\* provide:

PROTEIN . . . . .	32 Gm.	VITAMIN A . . . . .	3000 I.U.
FAT . . . . .	32 Gm.	VITAMIN B <sub>1</sub> . . . . .	1.16 mg.
CARBOHYDRATE . . . . .	65 Gm.	RIBOFLAVIN . . . . .	2.0 mg.
CALCIUM . . . . .	1.12 Gm.	NIACIN . . . . .	6.8 mg.
PHOSPHORUS . . . . .	0.94 Gm.	VITAMIN C . . . . .	30.0 mg.
IRON . . . . .	12 mg.	VITAMIN D . . . . .	417 I.U.
COPPER . . . . .	0.5 mg.	CALORIES . . . . .	676

\*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.





## *A Medical Man . . .*

. . . Wrote the first Life Insurance Policy in Hawaii in October, 1851—just 100 years ago, according to available records.

He was Dr. Gerrit P. Judd, one of our early medical missionaries and first member of one of Hawaii's First Families. The policy was the 3,630th issued by New England Mutual since its charter in 1835. Dr. Judd was the N.E.M. agent here for a number of years.

## **NEW ENGLAND MUTUAL LIFE**

**Insurance Company of Boston**

*100th Year of Service in Hawaii*

**GENERAL AGENT**

**HOME INSURANCE CO. OF HAWAII, LTD.**

Honolulu . . . King St. between Fort & Bishop

Maui—Lufkin Ins. Agency . . . . . Wailuku

Kauai—J. M. Lydgate, Ltd. . . . . Lihue

## *Relationship of Stress to Autonomic Lability*

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance.<sup>1,2</sup> Such states may involve any one of the organ systems or several at one time.<sup>1,3</sup> The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifestations	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure  
Body Temperature Variations  
Changing pulse rate  
Deviations in B. M. R.  
Exaggerated Cold Pressure Reflex  
Oculo-Cardiac Reflex Abnormalities  
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy\*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

\*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. 8,9,10.

1. Ebaugh, F.: Postgrad. Med. 4: 208, 1948. 2. Wilbur, D.: J.A.M.A. 141: 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. 42: 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. 27: 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. 107: 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. 58: 251, 1948.

*Sandoz  
Pharmaceuticals*

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, NEW YORK

*Effective against many bacterial and  
rickettsial infections, as well as certain protozoal  
and large viral diseases.*

# AUREOMYCIN

*Hydrochloride Crystalline*



## The Gastroenterologist

recognizes the remarkable inhibiting effect of aureomycin on a great number of organisms, especially those commonly found in the gastrointestinal tract. It is of great value in the preparation of patients for surgery of the bowel or biliary tract, as well as in the medical management of infections in these areas. Aureomycin is also highly effective in intestinal amebiasis. Aureomycin is peculiarly adapted to the treatment of many biliary and hepatic infections, because of the high concentrations it attains in the bile and because of its protection of the hepatic parenchyma from bacterial necrosis. Aureomycin is indispensable in gastroenterology.

### *Packages*

*Capsules:* Bottles of 25 and 100, 50 mg. each capsule. Bottles of 16 and 100, 250 mg. each capsule.  
*Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION

*AMERICAN Cyanamid COMPANY*

30 Rockefeller Plaza, New York 20, N. Y.



*YOU, Doctor, are the best judge, so*

# BELIEVE IN YOURSELF!

With so many claims made in cigarette advertising,  
most doctors prefer to judge for themselves.  
So, Doctor, won't you make this simple test?

Take a **PHILIP MORRIS—**  
and *any* other cigarette. Then,

1. Light up either one. Take a puff—don't inhale—and s-l-o-w-l-y let the smoke come through your nose.
2. Now do exactly the same thing with the other cigarette.



*Then, Doctor...BELIEVE IN YOURSELF!*

## PHILIP MORRIS

Philip Morris & Co. Ltd., Inc.  
100 Park Avenue, New York 17, N. Y.

# As if there were no germ of disease

Illness interferes with best growth. You want infants in your care to have every possible protection against disease in order to help maintain sure steady growth and development.

That's why so many physicians everywhere recommend Pet Evaporated Milk for infant formula. Sterilized in its sealed container, permanently protected from any source of contamination, Pet Milk is completely safe, as if there were no germ of disease in the world.

You are assured, too, that safe Pet Milk retains all the food values the best milk can be depended upon to supply . . . and that these food values are uniform wherever and whenever this good milk is purchased.

And it's thrifty! Pet Milk, the original evaporated milk, costs less than any other form of milk . . . far less than special infant feeding preparations!

Try Pet Milk for the babies in your care! Let this safe, low-cost milk help you in your continuous fight against disease!

**Favored Form  
of Milk for  
Infant Formula**



**PET MILK COMPANY, 1424-E Arcade Building, St. Louis 1, Missouri**





## ONE WORD WILL PROTECT YOUR RECOMMENDATION!

*Because "Carnation" assures you of*

- |           |                              |
|-----------|------------------------------|
| <b>1.</b> | <b>PRESCRIPTION ACCURACY</b> |
| <b>2.</b> | <b>COW-TO-CAN CONTROL</b>    |

**—both factors closely identified with Carnation Evaporated Milk**

The production of Carnation is unique in that every drop of Carnation is Carnation Milk —

- all prepared in Carnation's own plants
- all processed under Carnation's own supervision.

Thus, when you specify Carnation by name, you specify high and strictly uniform standards of evaporated milk production. You protect your recommendation by one single word — "Carnation."

This simple fact may explain why 8 out of 10 mothers who use Carnation Milk say: "My doctor recommended it."

*The Milk Every Doctor Knows*



*"from Contented Cows"*

# Cadillac



## The Car of TOMORROW for the People of TODAY

CADILLAC is years ahead in engineering accomplishment and design.

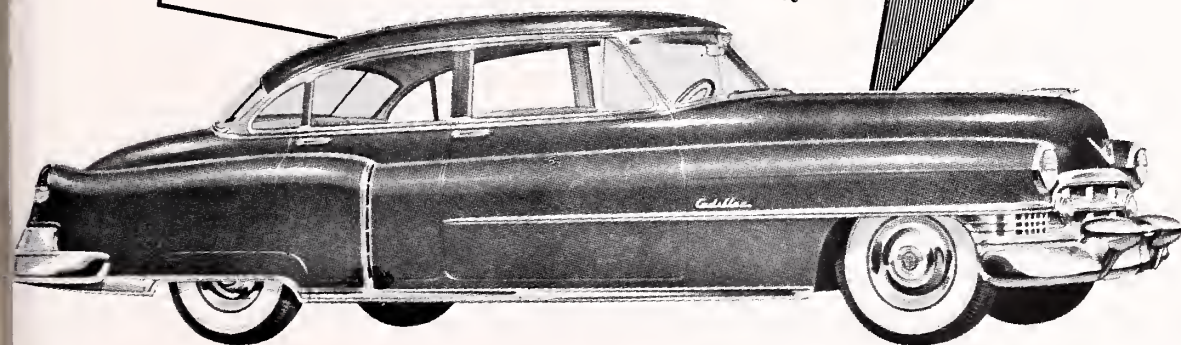
Today's 1951 CADILLAC is STILL the finest, most secure automotive investment you can make.

### Quality Pays In The Long Run

*When you own a CADILLAC, you are guaranteed years and years of luxurious motoring comfort and driving satisfaction.*

*When you own a CADILLAC, you can figure on a long life-span of flawless performance with minimum maintenance*

*When you own a CADILLAC, there's no time limit on its services to you*



Open Thursdays till 9:00 P. M.

Saturdays till 4:00 P. M.



## SCHUMAN CARRIAGE COMPANY

Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU



*Some Rx's are easy  
Some Rx's are hard,  
Their sources are varied,  
From extracts to lard.*

*So dream up some good ones  
And write 'em down pat,  
We'll "stat" to your patients  
Wherever they're at!*



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR • YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONE  
7-8411

**WHERE PHARMACY IS A PROFESSION**

# HAWAII MEDICAL JOURNAL

## and INTER-ISLAND NURSES' BULLETIN

Volume 11  
Number 2

NOVEMBER-DECEMBER, 1951

\$2.00 per year  
35c per copy

Published Bi-Monthly by  
THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

### Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
1951-1952

### OFFICERS

HARRY L. ARNOLD, JR., Honolulu.....	President
R. J. McARTHUR, Wailuku, Maui.....	President-Elect
T. DAVID WOO, Pepeekeo.....	Vice-President from Hawaii County
JOHN W. DEVEREUX, Honolulu.....	Vice-President from Honolulu County
K. K. FUJII, Kapaa.....	Vice-President from Kauai County
E. T. SHIMOKAWA, Lahaina.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

### COMMITTEE CHAIRMEN

GROVER A. BATTEN.....	Cancer Committee
TELL NELSON.....	Health Education Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	HAWAII MEDICAL JOURNAL
F. D. NANCE.....	By-Laws Committee
JOHN W. DEVEREUX.....	Advisory Board for Woman's Auxiliary
MORTON E. BERK.....	Diabetes Committee
ISAAC A. KAWASAKI.....	Public Service Committee
VERNE C. WAITE.....	Post-Graduate Committee
SAMUEL YEE.....	Legislative Committee

### OFFICERS — COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....T. David Woo, Pepeekeo	John W. Devereux	K. K. Fujii, Kapaa	Edw. T. Shimokawa, Lahaina
<i>Vice-President</i> .....S. Kasamoto, Hilo	Wm. M. Walsh	Keith Kuhlman, Koloa	John A. Burden, Paia
<i>Secretary</i> .....Francis Wong, Hilo	Wm. S. Ito	C. H. Ishii, Lihue	Edward Kushi, Wailuku
<i>Treasurer</i> .....Richard Hata, Hilo	C. M. Burgess	C. H. Ishii, Lihue	Edward Kushi, Wailuku

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1951, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.





## Enduring Strength

### *... Built on a Solid Foundation*

Proper nutrition for the infant in the early months of life is vitally important. It is during this period precisely when it is necessary to establish a solid foundation for the child to develop healthy and strong.

#### DRYCO IDEAL FOR FEEDING IN WARM CLIMATES

The very young infant needs protein in substantial quantities to fulfill demands of rapid early growth and to build new tissue. DRYCO, with its high protein, meets these demands. And the modified fat content of DRYCO provides adequate amounts of this element while minimizing digestive disturbances. In warm or tropical climates, this is a signal advantage!

#### SPECIALLY PACKED TO RETAIN FRESHNESS

DRYCO is the best fresh milk, consistently good, easily digested, and vitamin enriched. It is specially packed in vacuum-sealed tins to retain its original freshness and nutrition in any climate.

# DRYCO

*To obtain promptly more information and feeding schedules, address a card or letter to:*

**THE BORDEN COMPANY**  
(Export Division)

350 Madison Avenue  
New York 17, N. Y., U. S. A.

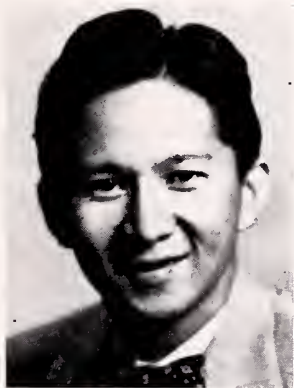


# Accidental Poisoning in Children

## With Special Reference to Kerosene Poisoning

L. T. CHUN, M.D.\*

HONOLULU



DR. CHUN

**T**HIS STUDY on accidental poisoning in children is the result of a review of cases admitted to the Kauaikeolani Children's Hospital over a five year period from August 1945 to May 1950. The purpose of this study was to determine the most frequent types of poisoning so that an emergency room could be set up at the Children's Hospital to meet the most common needs. No attempt has been made to determine the best method for managing any one particular type of poisoning, because when the cases were admitted there was no unified study made with this in mind.

The cases presented are those that were admitted to the Children's Hospital, and do not necessarily reflect the most common types that may be seen in private practice or at the local Emergency Hospital.

### Observations

The total number of cases admitted was 221 with 3 deaths, a mortality rate of 1.3%. The deaths were due to one each of the following: kerosene, oil of eucalyptus, and water color paint. The age range was from 10 days to 12 years with an average (median) age incidence of 3.8 years. The mode was 2 years: 40 cases occurred at this age, an incidence of 17.8%. The other ages in the order of frequency were: 1.5 years, 24 cases or 10.7%; 1 year, 20 cases or 8.9%; 3 years, 18 cases or 8.03%; 2.5 years, 17 cases or 7.6%. One hundred and forty-nine boys and 72 girls were admitted. There were 3 cases who ingested poisons twice. One was a 2½ year old female who ingested phenolphthalein in the form of "Ex-lax" twice 4 months apart. Another was a 3 year old male who was first admitted for ingestion of oil of eucalyptus and fourteen months later was ad-

mitted for kerosene ingestion. The third case was a 1 year old male who ingested kerosene twice five months apart.

There were 59 types of poisons encountered. To facilitate the discussion of the different types of poisoning, they have been divided into four major groups, namely, medications, chemicals, foods, and plants. The individual poisons encountered are as follows:

#### A. Medications

1. Oil of eucalyptus, 13 cases; phenolphthalein, 7 cases; barbiturates, 7 cases; salicylates, 6 cases; camphorated oil, 5 cases; rubbing alcohol, 4 cases; thyroid tablets, 3 cases.
2. There were two cases of each of the following: Benadryl; iodine; "Vapor Cresoline"; benzedrine; ethyl alcohol; aconite.
3. There was one case of each of the following: "Antistine"; potassium permanganate; stilbestrol; morphine; mercury; atropine; sulfonamide; mercurochrome.

#### B. Chemicals

1. Kerosene, 69 cases; arsenic, 17 cases; pine oil, 7 cases; turpentine, 4 cases.
2. There were three cases of each of the following: Cigarette lighter fluid; carbon tetrachloride; ant poison (unidentified).
3. There were two cases of each of the following: Phosphorus, gasoline, water color paint, nicotine, "Clorox," "Flit," lye, inhalation of "Chemtox" (termite fumigation fluid), creosol.
4. There was one case each of the following: Vanilla extract, witch hazel, creoline, "Tintex" dye, nail polish remover, incense sticks, D.D.T., shoe polish, "Borax," "trupine," denatured alcohol, lacquer thinner, camphor crystals, lead, weed poison (unidentified).

#### C. Foods (spoiled)

1. Butter fish, 7 cases; black sea bass, 1 case; cream puff, 1 case; corned beef, 1 case.

#### D. Plants

1. Berries (unidentified), 2 cases; nuts (unidentified), 3 cases; fruit (unidentified), 1 case; Dieffenbachia (dumb cane), 1 case.

The most common general treatment employed for the ingested poisons was gastric lavage. Out of the 221 cases admitted, 167 were so treated. Thirteen had vomited prior to the lavage, and of these, it was induced in 7 by home remedies of milk, egg and milk, egg white, or mustard water. Ten were given emetics at home with no success. Most of the cases were treated by the Emergency Hospital before being admitted to the Children's Hospital.

On reviewing the cases, it was found that in

From the Kauaikeolani Children's Hospital of Honolulu.  
Read before the Honolulu Pediatric Society, May 3, 1951. Received  
or publication June 22.

\* Former Chief Resident Physician of the Kauaikeolani Children's  
hospital.



most instances, the exact amount of ingested poisons was unknown. The time interval before the patient was seen was usually from one-half hour to one hour. The following is a discussion of the more commonly encountered poisons:

### Commonest Poisons

Of the 13 cases of *oil of eucalyptus* ingestion, in 5 it was given as cough medicine by mistake. The most common symptom reported was convulsion, which occurred in 6 cases. Respiratory depression occurred in 3 cases; in 5, no common signs or symptoms were recorded. The symptoms appeared to be related not to the amount ingested but to how soon after ingestion therapy was started. It was noted that those treated within one-half hour presented no unusual findings. The treatment was mainly lavage. The one fatal case of oil of eucalyptus ingestion occurred in an 8 month old infant who was said to have ingested 1 ounce and was not treated till two hours later. On admission, the child was cyanotic, convulsing, and comatose. The temperature was elevated and he died nine and one-half hours after admission without regaining consciousness. The essential findings at autopsy were "hydrothorax, hydroperitoneum, and acute hemorrhagic peritonitis."

Of the 7 cases of *phenolphthalein* ingestion, 5 were due to "Ex-lax" and 2 to "Feen-a-mint." The symptoms were confined to mild diarrhea. Treatments consisted of lavage and, in only 1 case, kapectate and paregoric.

The 7 cases of *barbiturate* ingestion showed drowsiness as the most common symptom. Five were treated by lavage, one case was given caffeine, and one other was given benzedrine.

Of the 6 cases of *salicylate* poisoning, 2 were due to oil of wintergreen, and 4 to aspirin. The 2 cases of oil of wintergreen poisoning showed signs of acidosis on admission and were treated with glucose water and lactate solution parenterally. The one other case showing signs of acidosis on admission gave a history of ingesting 5 grains of aspirin once or twice every hour for one week, through a mistake in following directions. He had a salicylate level of 21.7 mg% on admission.

Of the 5 cases of *camphorated oil* poisoning, only one showed signs of intoxication. The child convulsed shortly after ingestion of the poison and had two more convulsions after admission to the hospital. She was treated by lavage only and given sulfadiazine for an associated nasopharyngitis. The next day she was free of symptoms.

Thirteen of the 17 cases of *arsenic* ingestion were due to cockroach powder and paste containing lead arsenate as the main ingredient. One

other was due to rat poison and the three others occurred simultaneously in siblings who drank a garden spray solution containing an arsenic compound. The exact amount ingested and whether the poison was actually swallowed could not be determined with certainty in all the cases. Only those three siblings who drank the garden spray solution showed toxic effects. They complained of vomiting and abdominal pains and were treated with BAL.

There were 7 cases of *pine oil* ingestion. Spiking fever a few hours after ingestion and lasting for about twelve hours was reported in 4 cases. One case had hyperemia and swelling of the mucous membrane of the oropharynx and signs of croup. Every case was treated by gastric lavage.

Three of the 4 cases of *turpentine* ingestion developed abnormal signs and symptoms, including fever of short duration. One of them had pneumonia, which was confirmed by x-ray. The other had convulsions, became cyanosed, and had urinary retention. He also developed polymorphonuclear leukocytosis.

Two of the 3 cases of *cigarette lighter fluid* ingestion developed fever for three days. One of the cases also showed lethargy and had findings of pneumonia both by physical examination and x-ray. Blood counts on this patient taken on admission and two days later were normal. Four days after admission, he had an anemia of 2.9 million red cells and 9 gram of hemoglobin which responded favorably to blood transfusion.

Two of the 3 cases of *carbon tetrachloride* ingestion had fever and leukocytosis on admission. One of them became extremely ill with jaundice and anemia of 1.11 million red cells, 19% hemoglobin, 21% nucleated red cells, and 59,000 leukocytes. The urine showed 3+ albumin and was normal six days later. The anemia was corrected with two blood transfusions. There was no record of any liver function tests.

Of the 7 cases of poisoning due to spoilage of butter fish, 5 involved children who were at the same party. The outstanding symptoms were nausea, vomiting, and diarrhea. No specific treatment was employed. The 2 other cases were siblings who had similar symptoms and were admitted a day before the other five. The other cases of food poisoning due to spoilage all had similar symptoms of nausea, vomiting, and diarrhea.

The fatal case of *water color paint* ingestion involved a 17 month old girl who ingested an unknown quantity of yellow, green, and blue water color paint. She was admitted to the hospital eight hours later in a semicomatose condition, having rapid and shallow respirations, vomiting, and

bloody diarrhea. She was treated with parenteral fluids but failed to respond and died five hours later following an attack of convulsions. The only significant finding from the coroner's report was acute pulmonary edema. The one other case of water color paint ingestion showed no unusual symptoms. He was lavaged within an hour after ingestion of the water color paint.

### Less Common Poisons

It might be of interest to mention briefly some of the outstanding findings of the other cases of poisoning that were less frequently encountered.

One of the cases of *iodine* poisoning had a mild burn of the lip. The 2 cases of *benzedrine* poisoning showed hyperexcitability which was controlled with barbiturates. Whiskey and beer accounted for the 2 cases of *ethyl alcohol* poisoning. Inebriation was the presenting symptom. Two of the 4 cases of *rubbing alcohol* poisoning were drowsy, flushed, and had fever. One of them ingested the alcohol, and the other had the alcohol given as an enema by accident. One of the patients who had no symptoms was a 10 day old infant who had the alcohol poured into his mouth by an older sibling. The 1 case of *morphine* poisoning received  $\frac{1}{2}$  grain by accident and became extremely drowsy. The case of *sulfonamide* poisoning developed urinary obstruction from precipitation of the sulfonamide crystals in the urethra. He was successfully treated by catheterization.

One of the cases of *ant poison* ingestion had a temperature elevation of  $102^{\circ}$  for eight hours. The 2 cases of *gasoline* ingestion had temperature elevations. One of them had transient rales in the chest. One of the cases of *nicotine* ingestion was admitted in a collapsed condition. He was successfully treated by gastric lavage. Both cases of "*Clorox*" ingestion had second degree burns of the oropharynx. No systemic effect was noted. One of the cases of "*Flit*" ingestion was admitted in a shocked condition with heavy grunting respirations. The other case had no systemic effects but experienced coughing and choking. Only one of the cases of *lye* ingestion was reported to have burns of the oropharynx with febrile reaction. No further complication developed. The two siblings who were involved in the termite fumigating fumes (*Chemtox*) had fever, wheezing, labored respirations, and polymorphonuclear leukocytosis. Inebriation was the only symptom noted with the *vanilla extract* ingestion. The child who ingested the *nail polish remover* was said to have had difficulty in breathing immediately after the accident but had no unusual symptoms when seen at the hospital an hour later. Cyanosis of the nail beds

and slight temperature elevation, resulted from the ingestion of unknown quantities of *shoe polish*. The patient was lavaged on admission and on discharge two days later was entirely well. The child ingesting the "*Borax*" complained of a stomach ache but was symptom free after the gastric lavage. The case of *lead* poisoning occurred in a  $1\frac{1}{2}$  year old boy who gave a history of ingesting paint over a period of time. He was admitted because of convulsions. X-rays showed deposition of heavy metal at the ends of long bones. Sodium luminal was used for controlling the convulsions. No specific deleading procedure was carried out.

One of the cases of *berry* poisoning had nausea and vomiting on admission but was not severely ill. The cases of *nut* poisoning involved 2 brothers and a friend. They all had vomiting and diarrhea immediately after ingesting the nuts. The case of *fruit* poisoning had nausea and vomiting. The case of *dieffenbachia* poisoning had abdominal pains only.

The cases not discussed presented no abnormal signs and symptoms. This in itself does not mean that the poisons were harmless. Many factors are responsible for this, such as, the small amounts taken, the poisons not being actually swallowed, and the early institution of treatment, mainly, gastric lavage.

### Kerosene Poisoning

There were 69 cases of kerosene ingestion, an incidence of 31.3%. The age range was from 11 months to 8 years with an average age of 21 months. The mode was 2 years—14 cases occurred at this age group, an incidence of 20.3%. The other ages in the order of frequency were: 1.5 years, 13 cases or 18.8%; 1 year, 11 cases or 15.9%. There were only two children over 3 years of age, a 4 year old and an 8 year old. The age incidence emphasizes the fact that children at the "age of exploring" are the ones most likely to get into trouble. In most instances, the accident occurred when the kerosene was kept carelessly in open cans, soda pop bottles, or containers with leaking spigots. The exact amount of kerosene ingested could not be determined accurately in most instances; estimates varied from a sip to a mouthful.

Gastric lavage was employed in 62 of the 69 cases. Three had spontaneous vomiting prior to admission and in four others there was no record of either lavage or vomiting. Sixteen patients received penicillin for prophylaxis and for treatment of pneumonia; one received sulfonamide alone, and two patients received both penicillin



and sulfonamide. Plain water was used for gastric lavage in 54 cases and the other 8 were lavaged with sodium bicarbonate solution. In 12 cases, the gastric lavage was followed by the instillation of some medication — 8 received milk of magnesia, 2 each received mineral oil and plain milk, and 1 each received olive oil and magnesium sulfate.

The most frequent complications are as listed in Table 1. An attempt has been made to group them into cases who were lavaged and those who were not. Because of the insufficient number of cases in the group not lavaged, no conclusions can be drawn from this study as to the frequency of complications between those who were lavaged and those who were not. There were 12 cases (17.3%) who presented no symptoms, and these were all in the group of cases who were lavaged.

TABLE 1.—Complications from Kerosene Poisoning.

COMPLICATIONS	TOTAL NO.	PERCENT OF TOTAL (69)	LAVAGED (TOTAL 62)		NOT LAVAGED (TOTAL 7)	
			NO.	%	NO.	%
1. Fever .....	52	75.3	44	70.9	7	100.0
2. Coughing & Choking .....	15	21.7	11	17.7	4	57.0
3. Pneumonia .....	13	18.8	10	16.1	3	42.8
4. Vomiting .....	10	14.4	10	16.1	....	....
5. Lethargy .....	9	13.0	9	14.5	....	....
6. Elevated WBC & Polys .....	6	8.6	5	8.0	1	14.3
7. Death .....	1	1.4	1	1.6	....	....

The fever was observed usually after the child had been in the hospital from four to eight hours and was of short duration, lasting twelve to twenty-four hours. The temperature varied from 101° to 104°. Those cases with pneumonia had longer duration of fever lasting from three to five days.

The coughing and choking recorded were those observed at the time of hospitalization. More detailed histories might have revealed these symptoms to be prevalent in the other cases also.

In 9 instances, the pneumonia was confirmed by x-rays, which showed a peribronchial infiltration in the lower lobes. The physical findings recorded were slight impairment to percussion and moist rales over the involved areas.

Most of the cases of vomiting occurred spontaneously after ingestion of the kerosene, though some were induced at home with emetics.

The lethargy ranged from drowsiness of short duration to unconsciousness of two to four hours' duration. One case was reported as being semi-comatose for eight hours.

Every case had a routine CBC on admission. Only 6 showed an elevated white count, ranging from 15,000 to 33,000 neutrophils ranging from 52 to 76%. Only 1 case developed anemia which occurred six days after the ingestion of kerosene and responded well to blood transfusion.

The one fatal case of kerosene ingestion oc-

curred in a 1½ year old child. The exact amount ingested was not known. She was lavaged at the Emergency Hospital about an hour after the onset of the accident and on admission to the Children's Hospital, the child was unconscious and gasping for breath. She expired forty minutes after admission.

### Discussion

It is beyond the scope of this paper to discuss all the different types of poisoning as each type would deserve a full paper discussion. The reader is referred to the excellent discussion of this subject by Dr. J. M. Arena in the *Ciba Clinical Symposia*.<sup>1</sup> However, since kerosene was the most common one encountered, a brief review of the literature on kerosene poisoning may be in order.

The subject of pulmonary manifestations following kerosene ingestion is always of considerable interest. Pneumonia occurs more frequently than we are led to believe. Lesser et al.<sup>2</sup> x-rayed 22 patients following kerosene ingestion and found 77% had signs of pneumonia. Of these, only 24.2% showed physical signs which appeared about four hours after ingestion. Reed et al.<sup>3</sup> followed 19 cases of pneumonia due to kerosene for six months to four years. They found no evidence of residual damage to the respiratory systems. The pulmonary changes resolved in two weeks. The cases at the Kauaikeolani Children's Hospital were not x-rayed routinely, hence, the incidence of pneumonia may have been higher than 18.8%.

The institution of gastric lavage as treatment in kerosene ingestion is controversial. The issue is about the mode of developing pneumonia. Lesser et al.<sup>2</sup>, Waring<sup>4</sup>, and Reed et al.<sup>3</sup> have shown by experiments with rabbits that pneumonia is caused by direct aspiration of kerosene into the lungs and that no pneumonia was observed when kerosene was instilled directly into the stomach. Rabbits were used in the experiment because they do not vomit. Deichmann et al.<sup>5</sup>, on the other hand, have shown that pulmonary changes can occur without direct aspiration of kerosene into the pulmonary system. When kerosene is introduced directly into the stomach, pulmonary changes can occur from absorption into the blood stream.<sup>5</sup>

In the above experiments, all mentioned that drowsiness occurred when large amounts of kero-

<sup>1</sup> Arena, J. M.: Accidental Poisoning in Children, *Ciba Clinical Symposia*, Vol. 3, No. 3, April-May '51.

<sup>2</sup> Lesser, L. I., Weens, H. S., McKey, J. D.: Pulmonary Manifestations following Ingestion of Kerosene, *J. Pediatr.* 23:352 (Sept.) 1943.

<sup>3</sup> Reed, E. S., Leikin, S., and Kerman, H. D.: Kerosene Intoxication, *Am. J. Dis. Child.* 79:623 (Apr.) 1950.

<sup>4</sup> Waring, J. I.: Pneumonia in Kerosene Poisoning, *Am. J. Med. Sci.* 185:325 (Mar.) 1933.

<sup>5</sup> Deichmann, W. B., Kitzmiller, K. V., Wintherup, S., and Johansmann, R.: *Ann. Int. Med.* 21:803 (Nov.) 1944.

sene were instilled into the stomach. Degenerative changes in the liver, kidneys, lungs, and heart have also been described.<sup>5</sup> At a recent clinical conference at the St. Louis Children's Hospital<sup>6</sup>, the occurrence of mediastinal and subcutaneous emphysema and pneumothorax in kerosene poisoning have been pointed out as not being unusual.

The observations made on the complications of kerosene poisoning in this study are similar to those made by others. Leukocytosis is the only exception. While this study reported an incidence of 8.6%, Reed et al.<sup>3</sup> report leukocytosis in 65% of their cases.

### Lead Poisoning

Because lead poisoning in children is unlike that in adults, brief mention will be made of another case of lead poisoning which occurred after this study was completed. The case was that of a 2 year old girl admitted because of an acute onset of convulsions not associated with fever. A careful history revealed the fact that the child had been eating paint off the wall over a period of 2 months. A flat x-ray of the abdomen showed scattered dense shadows in the shape of paint peelings. Blood level for lead was 0.8 mg%.

Increased intracranial pressure and cerebral edema are the outstanding features of lead poisoning in children. Therefore, it is hazardous to do lumbar punctures on patients with acute lead encephalopathy. In the chapter on lead poisoning in Mitchell and Nelson's *Textbook of Pediatrics*<sup>7</sup> it is stated that approximately one-half of the infants and small children have encephalitic manifestations and among these the mortality is about 25%. Of those who recover, about one-third are left with permanent neurologic sequels. Encephalitis with convulsions may be precipitated in a quiescent case by the release of the lead from the bones during an intercurrent acute infectious or metabolic disturbance. Because of the permanent residual effects that may develop from lead poisoning, the public should be educated to use lead-free paint in all house interiors and toys.

### General Measures

At the Conference on Poisoning at the Duke Hospital<sup>8</sup> in 1947, it was said that 400 different types of poisons kill over 500 children in America annually. Caustic alkali poisoning was said to be the most frequent, followed by kerosene. It was emphasized that many of the cases of poisoning were preventable and the responsibility is with

the parents. They suggested the following emergency measures in handling acute poisonings.

1. Identify the poison as soon as possible.
2. Evacuation of the poison from the stomach by lavage or emetic except in cases of kerosene and caustic alkali poison.
3. Antidoting the residual poison in the stomach when possible.
4. Antagonist when available.
5. Symptomatic treatment when indicated.
6. When the nature of the poison is unknown, give universal antidote of: pulverized charcoal 2 parts, tannic acid 1 part, magnesium oxide 1 part. The pulverized charcoal may be given in the form of burnt toast, the tannic acid in the form of strong tea, and the magnesium oxide in the form of milk of magnesia. The first will absorb phenol and strychnine, the second will precipitate alkaloids, glucosides and metals, and the last will neutralize acids.

### Summary

A study of 221 cases of accidental poisoning admitted to the Kauaikeolani Children's Hospital over a 5 year period is presented.

Fifty-nine different poisons were encountered.

There were twice as many boys as girls admitted.

The age of greatest frequency was 2 years, followed by the age groups of 1½ years, 1 year, 3 years, and 2½ years.

Kerosene poisoning is the most common, and 69 cases of kerosene poisoning are presented in detail with a brief discussion of the literature.

Other more common types of poison are: arsenic compounds, oil of eucalyptus, phenolphthalein, barbiturates, pine oil, salicylates, and camphorated oil.

There were 3 deaths, due to one each of the following: kerosene, water color paint, and oil of eucalyptus.

### Conclusions

This study probably does not give a complete picture of the most common poisons encountered in the Hawaiian Islands. In order to have this study complete, further information should be obtained from the practicing physicians and the cases of poisoning admitted to the Emergency Hospital should be reviewed.

There are, however, two important points this study emphasizes:

1. Many of the cases of accidental poisoning are preventable.
2. We must never underestimate the 18 month to 3 year old child's knack for getting into trouble, and we recognize his natural curiosity for exploring the unknown through his mouth.

<sup>5</sup> Clinical Conference at the St. Louis Children's Hospital, "Mediastinal Emphysema, Pneumothorax, and Subcutaneous Emphysema Complicating Kerosene Poisoning", *J. Pediat.* 38:646 (May) 1951.

<sup>7</sup> Mitchell, A. G., and Nelson, W. E.: *Textbook of Pediatrics*, ed. 4, Phila., W. B. Saunders Co., 1945.

<sup>8</sup> Clinic on Poisoning, Conference at Duke Hospital, *J. Pediat.* 32:207 (Feb.) 1948.



# Some Common Arrhythmias and Their Treatment with Lanatoside C (Cedilanid)

F. BERNARD SCHULTZ, M.D.  
HONOLULU

**A**URICULAR flutter and fibrillation are most often seen in organic heart disease, commonly in rheumatic heart disease. They are likewise seen in thyrotoxicosis, hypertensive heart disease and coronary artery disease associated with arteriosclerotic heart disease.



DR. SCHULTZ

We have relied in the past, for controlling cardiac arrhythmias, largely upon such drugs as quinidine, procaine, magnesium sulphate, potassium chloride, atropine sulphate, papaverine, morphine and acetylcholine, etc. While these drugs are certainly useful, they are frequently ineffective and possess other disadvantages. They sometimes produce side effects such as tinnitus, nausea, vomiting, diarrhea, syncope, ventricular fibrillation, ventricular tachycardia, respiratory failure and cardiac arrest. The ideal drug, which will give the effect desired, must have the following properties: a short latency period and a quick onset of action, a rapid elimination and therefore no danger of accumulation, free from side effects and a wide therapeutic range. Such properties are found in Cedilanid\* (Lanatoside C), a chemically pure cardiac glycoside from *Digitalis lanata*.

Rothlin<sup>1</sup> found that the weak fixation to serum albumin of Cedilanid and the strophanthus glycosides, explains their comparatively short latent period. Stead, Warren and Brannon<sup>2</sup> observed that after administration of 0.8 to 1.6 mg. of Cedilanid, cardiac output begins to increase within ten minutes. Tandowsky, Anderson and Vandeventer<sup>3</sup> reported that simultaneously, ECG changes

follow and according to LaDue and Fahr<sup>4</sup>, Kroetz<sup>5</sup>, and Stead, Warren and Brannon<sup>2</sup>, the venous pressure begins to fall after about fifteen minutes and the heart decreases in size within thirty minutes to two hours. Rothlin<sup>6</sup> and his co-workers have shown in animals that the fixation by organs varies with the glycosides used and determines the degree of reversibility of their action on one hand and their storage and toxic cumulation on the other; also that digitoxin has the highest fixation power with a decrease in sequence from Digilanid (complex glycosides of *Digitalis lanata*) over Cedilanid and Scillaren A to the *Strophanthus* glycosides. Similar differences in fixation power and reversibility apply to the human heart. 12.7% of the lethal dose (constant infusion method Hatcher-Brodie) of digitoxin can be given approximately 9.5 times to the cat before death occurs. On the other hand, 18% of the lethal dose of Cedilanid will kill only after 13 injections have been given. The total lethal dose in the experiment with digitoxin is therefore 1.2 times higher than the Hatcher-dose, whereas Cedilanid requires 2.3 times the Hatcher-dose to kill the animal. From this it may be seen that Cedilanid has a low toxicity, shows a wide therapeutic margin and that moderately large doses are decidedly less toxic than digitoxin. Diefenbach and Meneely<sup>7</sup>, DeGraff, Batterman and Rose<sup>8</sup>, Flaxman<sup>9</sup>, Moody<sup>10</sup> and Levine<sup>11</sup> reported toxicity in humans from digitoxin.

I would like to present a few cases of cardiac arrhythmias in which Cedilanid (Lanatoside C) has been employed. Our findings and results are

\* Presented during the Annual Meeting of the Territorial Medical Association, Honolulu, Hawaii, May 4, 1951. Received for publication August 9, 1951. Condensed for publication. The full text appears in the author's reprints.

\* Sandoz Pharmaceuticals, Division of Sandoz Chemical Works, Inc.

<sup>1</sup> Rothlin, E.: Some Aspects of the Differentiation of Cardioactive Glycosides, *Proc. Rudolf Virchow Med. Soc. N.Y.* 6:74, 1947.

<sup>2</sup> Stead, E. A., Jr., Warren, J. V. and Brannon, E. S.: Effect of Lanatoside C on the Circulation of Patients With Congestive Failure, *Arch. Int. Med.* 81:282 (March) 1948.

<sup>3</sup> Tandowsky, R. M., Anderson, N. and Vandeventer, J. K.: An Electrocardiographic and Clinical Study of Various So-Called Cardiac Drugs, *Am. Heart J.* 28:298 (Sept.) 1944.

<sup>4</sup> LaDue, I. S. and Fahr, G.: The Effect of the Intravenous Administration of Lanatoside C Upon the Output, Diastolic Volume and Mechanical Efficiency of the Failing Human Heart, *Am. Heart J.* 25:344 (March) 1943.

<sup>5</sup> Kroetz, C.: *Herztherapie*, Praxis 31:250 1942.

<sup>6</sup> Rothlin, E.: Beitrag zum Problem der Verteilung der Pharmaka im Organismus im besonderen der herzwirksamen Glykoside, *Schweiz. Med. Wschr.* 74:217 (Feb.) 1944. Rothlin.<sup>1</sup>

<sup>7</sup> Diefenbach, W. C. and Meneely, K.: Digitoxin—A Critical Review, *Yale J. Biol. and Med.* 21:421 (May) 1949.

<sup>8</sup> DeGraff, A. C., Batterman, R. C. and Rose, O. A.: Digitoxin, Its Evaluation for Initial Digitalization of the Patient with Congestive Heart Failure, *J.A.M.A.* 138:475 (Oct.) 1948.

<sup>9</sup> Flaxman, N.: Digitoxin Poisoning, *Am. J. Med. Sci.* 216:179 (Aug.) 1948.

<sup>10</sup> Moody, R. W.: Maintenance Dose and Toxicity of Digitoxin, *Ann. Int. Med.* 34:1349 (June) 1951.

<sup>11</sup> Levine, H.: Abnormal Heart Rhythms in Digitoxin Therapy, *J.A.M.A.* 140:786 (July) 1949. Levine.<sup>12</sup>

<sup>12</sup> Levine, H.: Abnormal Rapid Rhythms Associated with Digitoxin, *Ann. Int. Med.* 29:822 (Nov.) 1948.

based upon careful clinical observations and electrocardiographic findings. Cedilanid (Lanatoside C), has been extensively tested both experimentally and clinically and numerous observers have extolled the properties of Cedilanid, especially when given intravenously. We likewise found that the pulse deficit in cases of auricular fibrillation greatly improves in remarkably short periods, and that the ventricular rate in auricular fibrillation slowed down with considerable speed in comparison to other digitalis preparations such as digitoxin which we have used in the past. For the sake of brevity, and to avoid repetition, all the references are not quoted because this has been done in many previous publications, especially in an excellent monograph on digitalis by Movitt<sup>13</sup>.

Case Histories

CASE 1.—A 27 year old man who fell and received a 2½" laceration of his left temple was brought to the hospital fibrillating as shown in Fig. 1. Following the suturing of his laceration, he was given 1.6 mg. Cedilanid intravenously at 4:00 p.m. The following morning nor-

mal sinus (Fig. 2) rhythm had been restored and no further medication was given. A week later, no arrhythmia was found. Patient seen one month later with normal sinus rhythm.

CASE 2.—A Japanese woman, age 48, gave a history of having a weak heart since childhood. She had repeated bouts of this same kind of "heart attack." Physical findings were negative, except an extremely fast heart rate. She stated that "my heart has been acting up this way for the past week." An electrocardiogram was taken (Fig. 3) at 2:30 P.M. and 4 cc. of Cedilanid was given intravenously. Patient was seen at 2:15 P.M. next day and a second ECG was taken (Fig. 4). The first ECG shows auricular tachycardia with a rate of 166, the second ECG shows a normal sinus rhythm with a rate of 60. The patient stated that her heart had quieted down around 6:00 P.M., three and one-half hours following the injection. Had this patient been a hospital case, a larger dose of the drug would have been given and the reversion to normal sinus rhythm no doubt would have been much earlier.

CASE 3.—A 46 year old white man. History of two previous attacks of "my heart pounding and fluttering." Patient had a sub-total gastrectomy three years before. First "heart attack" six months ago following over indulgence in alcohol. Patient was seen at 10:30 A.M. with physical findings essentially negative except the heart was fibrillating (Fig. 11). Six cc. of Cedilanid

<sup>13</sup> Movitt, Eli R.: Digitalis and Other Cardiotonic Drugs, Second Edition, Oxford University Press 1949.



Fig. 1 (Case 1). Lead 2 showing auricular fibrillation.



Fig. 2 (Case 1). Lead 2 showing normal sinus rhythm after twenty-four hours. Treated with 1.6 mg. Cedilanid intravenously.

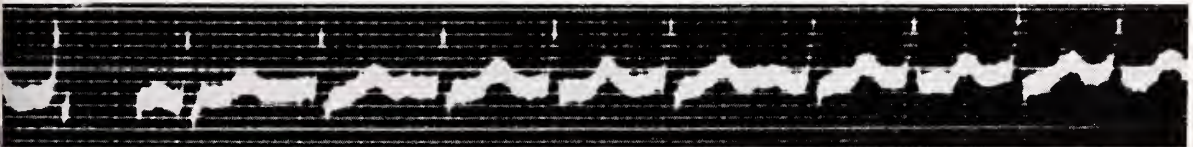


Fig. 3 (Case 2). Lead 2 showing auricular tachycardia.

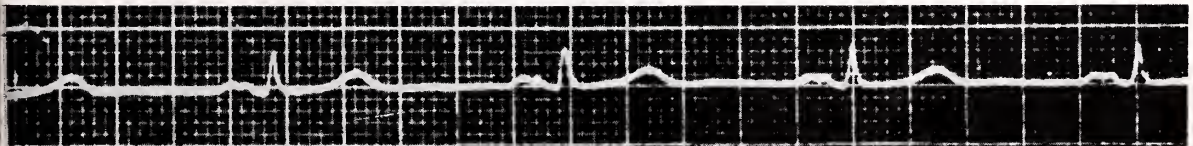


Fig. 4 (Case 2). Lead 2 showing normal sinus rhythm twenty-four hours after 4 cc. of Cedilanid was given intravenously.

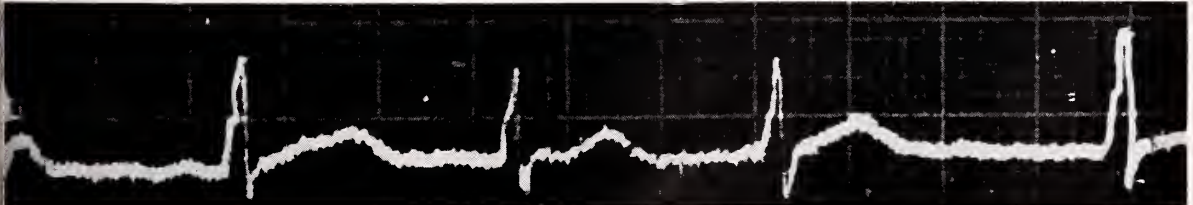


Fig. 11 (Case 3). Lead 2, showing auricular fibrillation.



was given intravenously. Five minutes later the pulse and ventricular rate were 78. Patient was seen the following morning when a second ECG was taken (Fig. 12) showing normal sinus rhythm.

CASE 4.—This was the third hospital admission of a 45 year old Hawaiian woman in acute congestive heart failure. She presented a four plus edema of the lower extremities, together with rales in both bases of the lungs. The heart was fibrillating (Fig. 5). The patient was not cooperative as to taking her digitalis preparation at home and we had no idea when the last dose was taken. She was given mercurial diuretics for one week and then digitalized with 1.6 mgm. of Cedilanid. The following day a second electrocardiogram was taken (Fig. 6). Although the fibrillation was not broken, the general appearance of the electrocardiogram was better, as well as a slowing and a more regular ventricular rate. Patient was discharged from the hospital after one

month and compensated on a maintenance dose of 0.333 mgm. Digilanid (chemically pure complex glycosides of *Digitalis lanata*, Lanatosides A, B and C) daily.

CASE 5.—A 16 year old Japanese woman who noticed her "heart skipping." The physical examination was essentially negative with the exception of the premature ventricular contractions. An electrocardiogram was taken (Fig. 7). One ampul (4 cc. Cedilanid) was given intravenously; twenty-four hours later she had resorted to normal sinus rhythm (Fig. 8). This patient has been apparently well since.

CASE 6.—A 46 year old rather obese Japanese woman was seen by another physician in his office and he noted a very rapid heart rate. The patient had been seen and was being treated for symptoms of menopause. The patient was sent to the hospital and referred for consultation and physical findings were essentially negative. An



Fig. 12 (Case 3). Lead 2: normal sinus rhythm twenty-four hours later after 6 cc. of Cedilanid had been given intravenously.

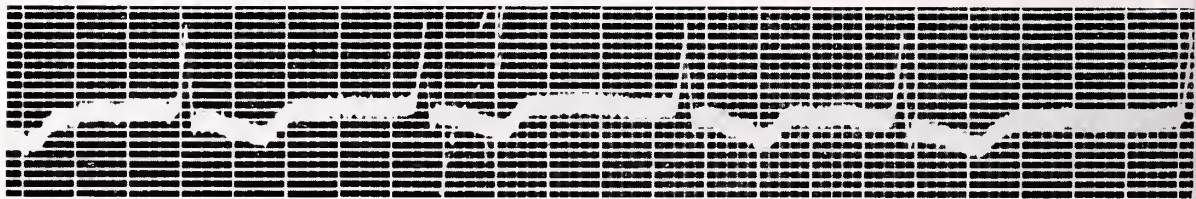


Fig. 5 (Case 4). Lead 2: auricular fibrillation.

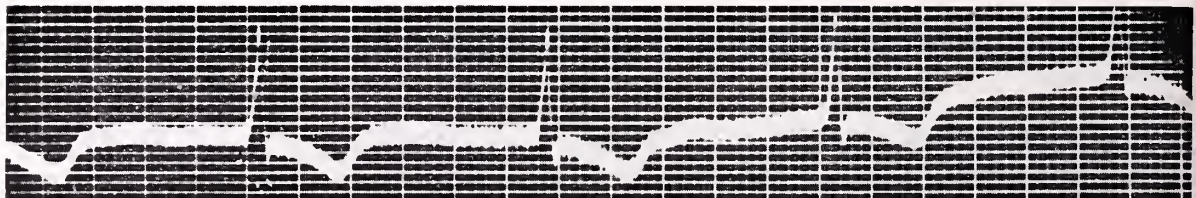


Fig. 6 (Case 4). Lead 2, twenty-four hours after 1.6 mg. of Cedilanid given intravenously. Still auricular fibrillation but a slower ventricular rate.

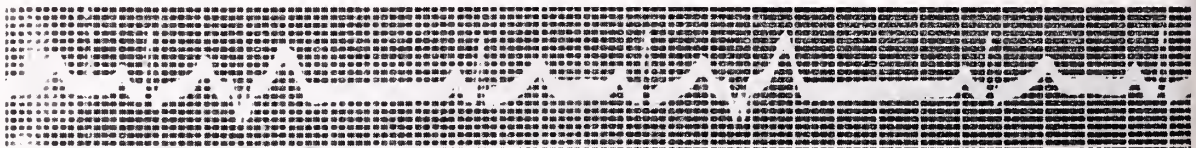


Fig. 7 (Case 5). Lead 2, showing premature ventricular contractions.



Fig. 8 (Case 5). Lead 2, showing normal sinus rhythm twenty-four hours after 4 cc. Cedilanid given intravenously.



electrocardiogram was taken (Fig. 9), and shows auricular fibrillation. Following the administration of 0.8 mgm. (4 cc.) of Cedilanid, the rhythm reverted to normal sinus rhythm within four hours (Fig. 10). The patient was maintained on 0.333 mgm. of Digilanid daily for three weeks and upon discharge, the heart and pulse rate averaged 76 beats per minute. Patient was taken off all medication except therapy for her menopause, and when seen one month later, she still was maintaining her normal sinus rhythm.

CASE 7.—Since the presentation of this paper, another case came under my care, a 9 year old Japanese boy. I catheterized his heart on February 13 of this year. Various laboratory tests were done and the electrocardiogram showed a normal sinus rhythm, with marked right axis deviation. During the catheterization, a direct writer was used with no change in the rhythm or rate. A diagnosis of Tetralogy of Fallot was made. The patient was posted for a Blalock-Taussig procedure March

26, 1951. On this morning a direct writer electrocardiograph was attached to the patient, as in all types of this surgery, and with the induction of intratracheal cyclopropane anesthesia, the tracings were begun. The first reading (Fig. 12) shows a very aberrant rhythm. Four cc. of Cedilanid was given intravenously through the tubing which contained the plasma-blood which was introduced into one of the foot veins. Ten to fifteen minutes later (Fig. 12) normal sinus rhythm had been restored. Surgery was then started and at five to ten minute intervals electrocardiograms were made as shown in the accompanying tracings (Fig. 13). Throughout the operation the average ventricular rate was 166. At 1:00 P.M. just prior to closing the chest wall and discontinuing the anesthesia, another dose of Cedilanid (4 cc.) was given intravenously. The last tracing just prior to the patient being taken to his room, shows a normal sinus rhythm. This child has had an uneventful recovery and is maintaining a normal rhythm.

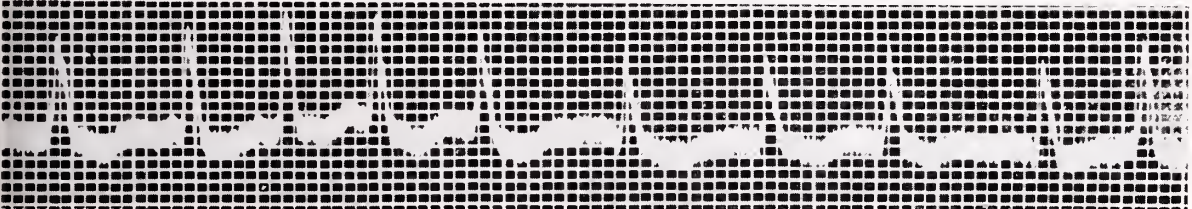


Fig. 9 (Case 6). Lead 2, showing auricular fibrillation.

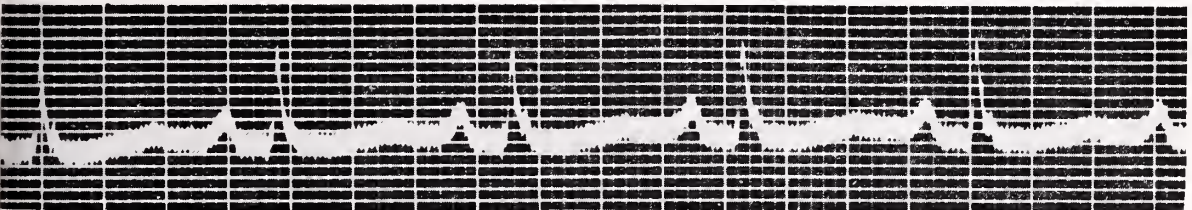


Fig. 10 (Case 6). Lead 2, normal sinus rhythm, 4 hours after 0.8 mgm. of Cedilanid had been given intravenously.

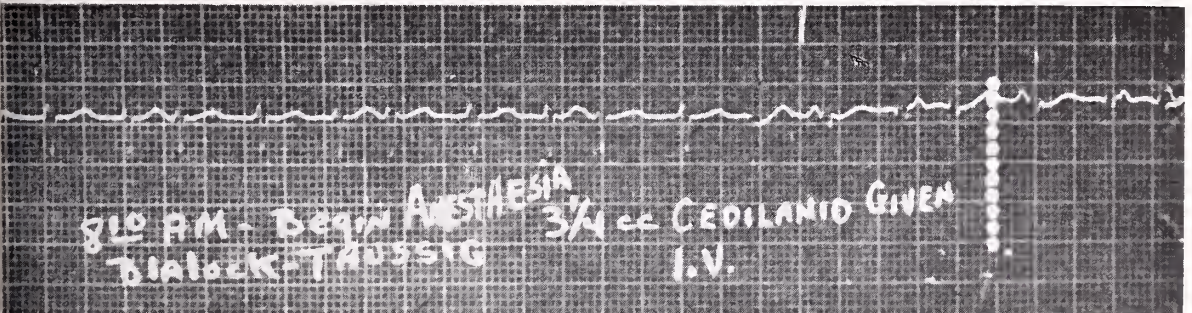


Fig. 12 (Case 7). Showing an auricular tachycardia with aberrant rhythm. Cedilanid 3 1/4 cc. given intravenously.

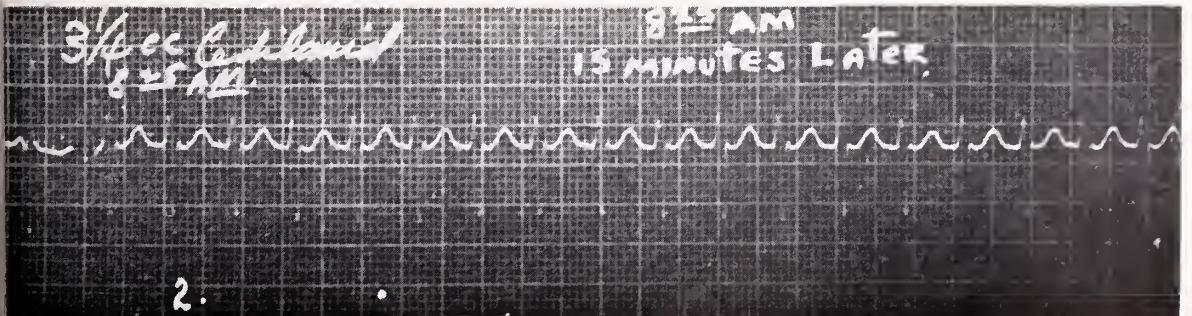


Fig. 13 (Case 7). Fifteen minutes later shows a normal sinus rhythm.



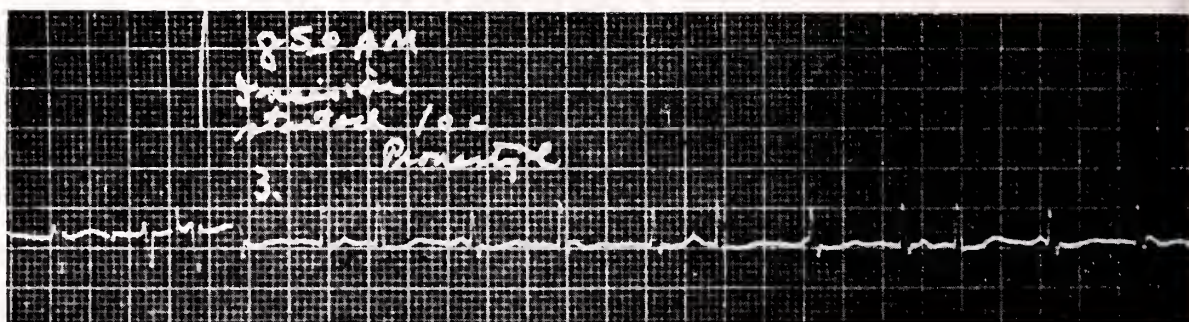


Fig. 14 (Case 7). Twenty-five minutes later, auricular premature beats. Pronestyl 1 cc. given intravenously.

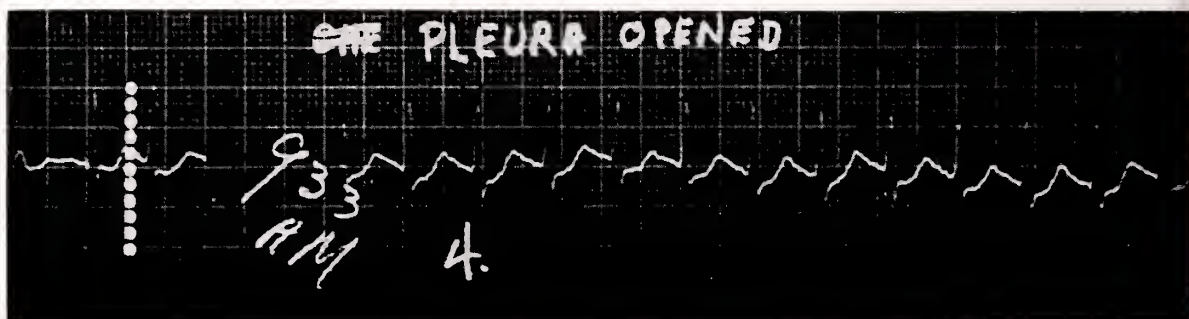


Fig. 15 (Case 7). Forty-three minutes later—still normal sinus rhythm.

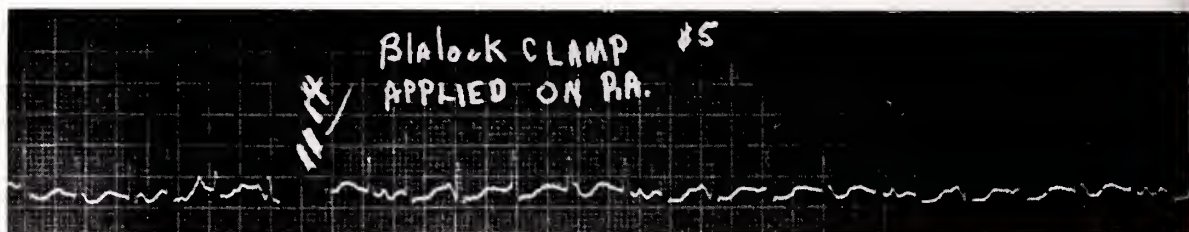


Fig. 16 (Case 7). Ventricular rate still fairly constant.

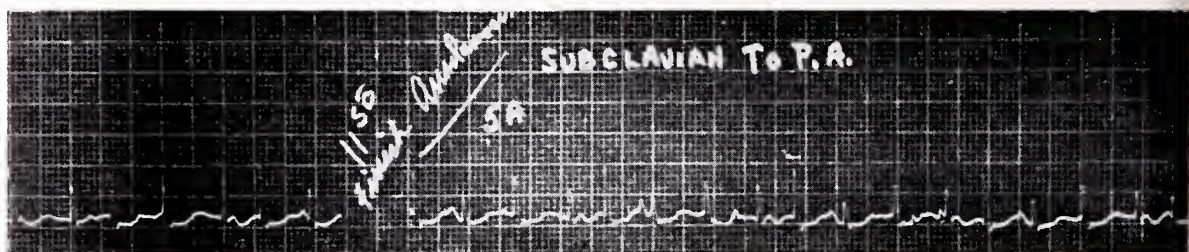


Fig. 17 (Case 7). Surgeon has completed the anastomosis of the subclavian artery to the pulmonary artery. No change in rate or rhythm.

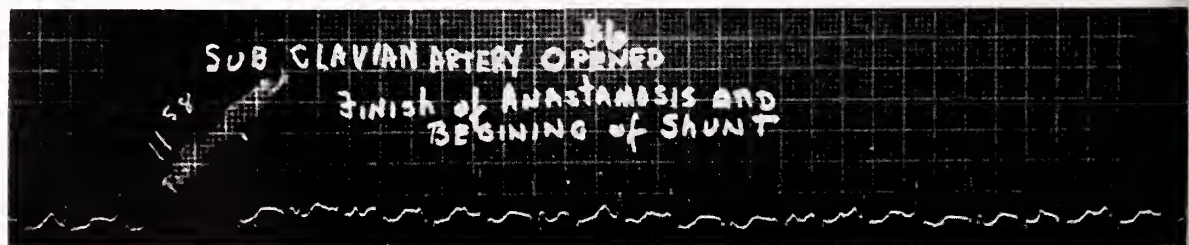


Fig. 18 (Case 7). Finish of the anastomosis and beginning of the shunt with subclavian artery open. No change in rate or rhythm.

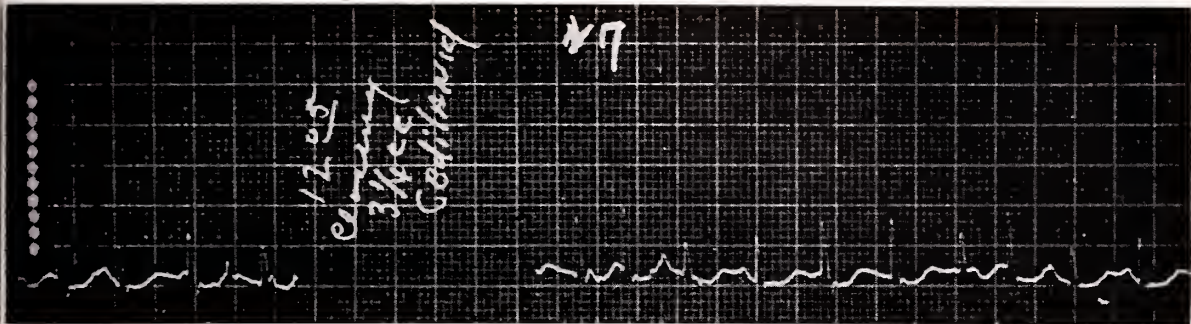


Fig. 19 (Case 7). Three hours after first dose of Cedilanid given appearance of premature auricular beats; 3¼ cc. of Cedilanid repeated.

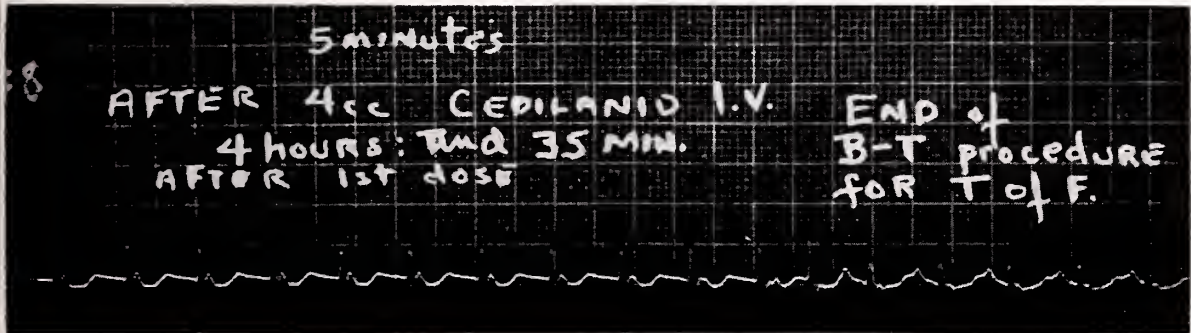


Fig. 20 (Case 7). Five minutes later and four hours and thirty-five minutes after first dose, rhythm has now become regular and has remained a normal sinus rhythm.

Conclusions

- 1. Lanatoside C is a safe and rapidly acting cardiac glycoside.
- 2. It possesses a wide therapeutic margin, is quickly eliminated and is less toxic than digitoxin.

- 3. It is effective in correcting some disorders of the heart beat which was shown clinically and electrocardiographically.

Young Hotel Bldg.



# An Epidemic of Conjunctivitis in Hawaii

WILLIAM JOHN HOLMES, M.D.  
HONOLULU

**D**URING THE first six months of 1951, 1963 new cases of acute follicular conjunctivitis were reported to the Hawaii Territorial Board of Health.

## Incidence

A spot survey of the population revealed that the disease was considerably more prevalent than the available statistics indicated. Many patients never consulted a physician at all; others sought help from druggists and family physicians who often failed to recognize the contagious nature of the affection and hence failed to report it; still others, living on military reservations, were treated at post dispensaries or military hospitals. Records from these sources show that the condition had been observed in a great many patients during the six months' period, but the exact number of cases seen was not known. From the foregoing, it seems likely that the total number of cases that occurred in Hawaii between January and June of 1951 was closer to five thousand than to the official figures on record. This means that approximately 1% of the total population had been infected.

## Clinical Course

The clinical picture was usually characterized by rapid onset of redness, foreign body sensation, sensitivity to light and some pain in one eye. The second eye was involved in about 50% of the cases. The lids usually remained unaffected or showed only slight edema. The tarsal conjunctivae exhibited a velvety follicular type of hypertrophy which extended into the fornices. Both the tarsal and bulbar conjunctivae were extremely hyperemic. Multiple petechial subconjunctival hemorrhages were usually noted. In its early phase, the disease was seldom accompanied by any discharge. In a few instances, around the fifth day, a scant serous discharge did become apparent. No real or pseudo membranes were encountered in the cases personally observed, nor were any reported. Com-



DR. HOLMES

plications were few. Corneal involvement was not noted and only a small percentage of patients showed a ciliary injection. Preauricular adenopathy or tenderness was not observed. The disease attacked patients from four to seventy years of age, in all walks of life, and was noted with approximately equal frequency among all races. The average duration of the disease was from four to twelve days. However, several patients were seen who clinically improved in a few days but had repeated recurrences for as long as six to eight weeks following the original infection.

## Treatment

In the treatment of this condition, many of the antibiotics were effective. The most dramatic "cures" were obtained by local instillations of solutions containing aureomycin or 30% sulfacetimide. However, the local use of penicillin, sulfathiazole, Gantrisin, bacitracin, terramycin and others have also brought about favorable results. The usual antiseptic drops containing mercury, silver, metaphen, etc., were of little value. In the more stubborn cases, local treatment was supplemented by the oral administration of aureomycin and chloromycetin with favorable results.

## Etiology

Repeated cultures, smears, and conjunctival scrapings failed to reveal any organism. In a few cases, late in the course of the disease, where secondary infection had set in, hemolytic streptococci and Koch-Weeks bacilli were found.

From the foregoing, it must be surmised that the agent in this disease was due to a virus with selective affinity for the eyes. It has been shown by Thygeson that some viruses possess affinities for particular tissues and several of them have their most important localization in the eye (inclusion blenorrhea, trachoma, etc.).

## Epidemiology

It is believed that the virus in this epidemic was spread by droplet transmission, by swimming in infected ocean water, and by contact. One attack did not confer lasting immunity against reinfection.

## Conclusion

The epidemic described was of viral origin and simulated both Beal's follicular conjunctivitis, and "swimming bath" conjunctivitis. It seemed in no way related to epidemic keratoconjunctivitis.

# Hawaii

## MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D.	Editor
MRS. EDITH C. BENNETT	Managing Editor
WILLIAM JOHN HOLMES, M.D.	News Editor
HASTINGS H. WALKER, M.D.	Advisory Board
HOMER IZUMI, M.D.	Advisory Board
PETE OKUMOTO, M.D.	Associate Editor, Hawaii
EDWARD S. KUSHI, M.D.	Associate Editor, Kauai
C. H. ISHII, M.D.	Associate Editor, Maui

### [ EDITORIALS ]

#### FIFTH PAN-PACIFIC SURGICAL CONGRESS

The Fifth Congress of the Pan-Pacific Surgical Association, which opens as we go to press, on November 12, set a new record of attendance at medical meetings in Hawaii: 241 local physicians and 281 visitors registered by the fifth day.

This year for the first time, the Congress is under the sponsorship of a separate organization, the Association, which has recently been formally incorporated under the laws of Hawaii by 10 charter members: the President and Secretary-Treasurer, Drs. F. J. Pinkerton and F. J. Halford; the 4 local councillors, Drs. J. E. Strode, C. E. Fronk, S. F. Stewart, and R. O. Brown; and 4 representatives of local surgical specialty societies, Drs. L. M. Wiig (Surgical Society), J. W. White (Orthopedic Society), H. E. Bowles (Obstetrical Society) and J. P. Frazer (Eye, Ear, Nose & Throat Society).

A preliminary Hospital Institute, jointly sponsored by the Association and the Hospital Association of Hawaii, was held on November 8 and 9. It was conducted by two eminent visitors, Drs. Edward H. Leveroos, Associate Secretary of the Council on Medical Education and Hospitals of the American Medical Association, and Dr. Anthony J. J. Rourke, Administrator of Stanford University Hospital and President of the American Hospital Association.

A cocktail supper party at the Officers' Club at Tripler Army Hospital on Sunday night preceded the formal opening of the meeting; it was in charge of the Ladies' Committee, headed by Mrs. Robert Johnston and consisting of Mrs. F. J. Pinkerton, Mrs. F. J. Halford, Mrs. J. Warren White, Mrs. C. M. Burgess, Mrs. Garton E. Wall, Mrs. Robert D. Millard, Mrs. Douglas Bell, and Mrs. Kyuro Okazaki.

Eminent visitors from all around the Pacific Ocean attended the meeting. Represented were: Alaska, Argentina, Australia, Canada, China, Japan, Korea, Mexico, New Zealand, the Philippines, the U.S.A., and Venezuela—and, of course, Hawaii.

The sessions were divided into general surgery sections and sections devoted to each of the various surgical specialties, each headed by a visiting chairman and a local vice-chairman. Four or five half-hour presentations were scheduled in most of the section sessions.

#### CORTICOTROPIN AND CORTISONE

Potentially dangerous though corticotropin ("ACTH") and cortisone are, it seems that they are doing, by and large, more good than harm. Their dangers are manifest largely after relatively prolonged use, as a result of which—paradoxically—they are even more useful in self-limited disorders than in the chronic and incurable diseases. Their high cost has militated against their excessive, indiscriminate or frivolous use: another example of the automatic, self-adjusting system of checks and balances that tends to establish itself under the system of free enterprise.

The statement that these hormones don't cure anything has been derided as "fashionable"; and lest this derision become fashionable, it may be desirable to reiterate the statement. They no more cure the diseases they control, than insulin cures diabetes, or thyroxin myxedema. Indeed, like both these long-familiar hormones, both corticotropin and cortisone exert a small but definite depressant effect upon their respective sources within the patient's body. If the disease being controlled by them terminates spontaneously before the hormones are stopped, it may seem to be cured; but



such an outcome depends upon either the interim disappearance of the causative agent, or the interim resumption of the patient's own natural supply of adrenal cortical hormones. The latter outcome seems to be favored by very gradual withdrawal of cortisone, or by concluding a course of cortisone with a few doses of corticotropin (ACTH). The problem of conducting patients safely through long periods of maintenance dosage seems, at the moment, one of the most important and also one of the most difficult which the clinician faces.

### LOWER MORTALITY, LOWER MORALITY?

The decline of human mortality in the past fifty years is one of the wonders of the age we live in. Its complexities—for it is complex indeed—are skilfully and lucidly outlined by Dr. Frank G. Dickinson (Ph.D.), Director of the A.M.A.'s Bureau of Medical Economic Research, in an address before the Fraternal Actuarial Association on May 21, 1951.

The crude death rate has fallen from 17.2 per 1,000 in 1900 to 9.6 in 1950, and the infant death rate from around 150 per 1,000 to around 30. In 1900, 3 newborns out of 4 could expect to live to be 21 years old; in 1950, 9.4 out of 10 could plan on living this long.

The mean age of death is up from 34 years to 59 years! The median age of death was 30 in 1900; now it is 66. The population of the U.S.A. has doubled since 1900, but the population over 65 years of age has quadrupled—from 3 million to 12 million.

In 1900, only 24 per cent of eligible voters were 50 years old or over; in 1950 35 per cent have lived this long; and the proportion is steadily rising. Townsendism, once a joke, is growing less funny, and perhaps less remote, as the years go by.

Pension benefits for displaced oldsters are here in force, and they are slowly but steadily being increased in scope and amount. This is good—in a purely materialistic sense, at least—for the older segment of the population; but it is being paid for by the younger. The battle of the welfare state is in a fair way to being fought not by socialists versus reactionaries, but by the old recipients versus the young providers.

Dr. Dickinson asks: "Are we, the aging, going to let this low standard of social morality to con-

tinue—to go even lower? For . . . it comes down to how much we are willing to exploit youth. . . . I am ashamed of the raw deal which my generation has given the next."

Food for thought, this; and the doctors, who have contributed in very large measure to bringing the situation about, might do well to think about it too. Some solution of it must be found; the direction we are headed leads only to eventual disaster.

### JAMES ALBERT MORGAN

1877 - 1951

Death claimed a kamaaina physician on September 25, 1951 when James Albert Morgan died after a long illness.

He was born in North Highlands, Mass., August 6, 1877, came to Honolulu in 1913 where he resided and practiced his specialty—otolaryngology and ophthalmology—until his retirement in 1945.

Doctor Morgan received his M.D. degree from Temple University in 1910. He received his pre-medical education at Little Blue School, Farrington, Me., Allens English and Classical School, West Newton, Mass., Cambridge Latin School, and Exeter Academy. Following graduation in medicine he served on the resident staff of the Philadelphia General Hospital. After this, through 1911-1913, he engaged in private practice in Philadelphia.

He was a member of the Honolulu County and Territorial Medical Associations, American College of Surgeons, American Academy of Ophthalmology and Otolaryngology, Pacific Coast Oto-Ophthalmological Association, and the American Society for Advancement of Science.

In addition to his professional activities he had many interests. He was a Mason, member of the Honolulu Rotary Club, member of the Board of Directors of the Protestant Episcopal Church, a member of the Board of Managers of the Army and Navy Corp., Y.M.C.A., a member of the Massachusetts Society of Mayflower Descendants, the Pacific Club, and the Oahu Country Club in Honolulu.

He was married to Elsie Edna Johnson at Media, Pa., in 1911. Mrs. Morgan and three sons survive him. They are James A., Jr., Woodland, Calif.; Dr. Andrew L., resident in urology, Veterans Hospital, Newington, Conn., and William Brewster, Honolulu.

His countless acts of kindness to many of us are known only to the recipients, but will always be remembered and appreciated.

G. A. BATTEN, M.D.

# MEDICAL NEWS

**Cortisone** is structurally similar to estrogen, which is inactivated in the liver. This **inactivation can be blocked with para-aminobenzoic acid**. In the hope that PABA would slow down the destruction of cortisone in the body, Wiesel, et al., gave the two drugs together to 15 rheumatoid arthritics and got a synergistic action: 25 mg. cortisone I.M. and 12 gm. PABA orally per day gave relief the same as or better than that obtained with standard doses of I.M. cortisone (100-200 mg. per day). (*Am. J. Med. Sci.* 222:243 [Sept.] 1951.)

Just shows you can't trust the *Ladies' Home Bazaar* and allied magazines: Reilly and Earle tried **methyl-testosterone** 5 mg. daily in 25 **premature infants** and found that 25 untreated prematures gained weight just as fast and went home just as soon. (*Am. J. Dis. Child.* 82:323 [Sept.] 1951.)

Dept. of "Which Page D'Ya Read?"

Greenblatt, et al. describe cures of intractable **Trichomonas vaginalis** vaginitis in 80 per cent of 48 women treated with insufflation of an **aureomycin-talc-lactose** powder. (*Am. J. Obst. & Gyn.* 62:423 [Aug.] 1951.)

While on page 452 Nayfield wonders about the **pruritus vulvae** which occurred in 4 of his patients following oral administration of **aureomycin**. (He found **monilia** in three, which responded to **propion gel**.)

**Cortisone** produced involution within 48 hours of an **erythema nodosum** which had been plaguing a pregnant woman for 3 months, report Farber and Mandelbaum. (*Arch. Int. Med.* 88:395 [Sept.] 1951.)

After 6 months of a downhill course with **pemphigus** (wt. loss from 235 to 118 lbs.) a patient experienced complete clearing of all lesions after 4 days' treatment with **Depo-Heparin** (200 mg. I.M. daily). Magner, et al. conclude with a magnificent understatement: "We are yet uncertain of the mechanisms involved."

Remissions in 17 patients with **pemphigus** (4 of them "malignant") obtained with **ACTH** and **cortisone** are described by Frazier, et al. in *Am. J. Med. Sci.* 222:308 (Sept.) 1951.

**ACTH** and **cortisone** produced improvement in symptoms and pulmonary function tests in a group of 9 patients with pulmonary emphysema studied by Lukas, but only in those patients who had **bronchiolar obstruction**. A bronchodilating action superior to epinephrine was demonstrated in 2 patients. (*Am. Rev. Tuberc.* 64:279 [Sept.] 1951.)

Wait until the American Tobacco Co. hears of this: T. H. Maren (Johns Hopkins) reports (*Proc. Soc. Exp. Biol. & Med.* 77:521 [July] 1951) that **nicotine** is not only a highly potent antipyretic and antidiuretic, but also has significant **adrenocorticotropic** action. ACTH will probably be replaced by ACTLS (After Cortisone Try Lucky Strike).

Gray, et al., describe dramatic remissions in 5 of 6 patients with **ulcerative colitis** and 2 patients with **regional ileitis**, after **ACTH** and **cortisone**. Relapses occurred (responsive to second course, and "maintenance" therapy). (*New Eng. J. Med.* 245:481 [Sept. 27] 1951.)

Kirsner and Palmer are also happy about the results obtained with these hormones in 27 of 40 patients with **ulcerative colitis**. (*J.A.M.A.* 147:541 [Oct. 6] 1951.)

The Hepatitis Center, 98th General Hospital, U. S. Zone of Occupation, Germany, reports with (surprising) enthusiasm on the effects of **ACTH** in **acute viral hepatitis**.

In all 5 patients treated there was prompt return of appetite and energy (whereby it became difficult to enforce bed rest), and a definite fall in serum bilirubin was noted, with relief of pruritus. On the debit side: no change in liver size or tenderness, and no change in liver function tests. Also, 4 of the 5 patients developed acute migratory polyarthralgia when ACTH was stopped. (Colbert, et al. *New Eng. J. Med.* 245:172 [Aug. 2] 1951.)

Barrett confirms the usefulness of **alumina gels** in the prophylaxis of **recurrent renal calculi**. Aluminum combines with ingested phosphate and the insoluble salt is excreted in the stool, reducing urinary phosphate excretion. Administration to 34 "stone-formers" for 2½ years was highly effective in preventing new calculi. "Basaljel" (Wyeth), an aluminum carbonate gel, was more effective than other aluminum gels, according to Barrett. (*J. Urol.* 66:315 [Sept.] 1951.)

Balfour, et al., are enthusiastic about **oral procaine** (4 cc. of 2% procaine in one dram of metamucil, t.i.d., ac.) in the treatment of painful **cardiospasm** in patients who are poor risks or who refuse dilatation of the esophagus. (*Gastroenterol.* 18:606 [Aug.] 1951.)

Dannenberg describes development of **tolerance to antihistaminics** in a majority of patients in 7 to 20 days. He advises **interrupted courses** if prolonged treatment is necessary. Return of effectiveness takes 3 to 14 days of abstinence from the drug. (*J. Allergy* 22:330 [July] 1951.)

The millennium—almost.

Boots and Company gave **cortisone** to eleven elders (ages 54 to 82) with degenerative joint disease of the hip, colloquially known as **malum coxae senilis**, obtaining relief of pain and increased range of motion in seven. (*J.A.M.A.* 147:549 [Oct. 6] 1951.)

But, Brown and friends tried cortisone in 8 such patients with benefit in only two. (*J.A.M.A.* *ibid.* p. 551.)

Economical treatment of **bronchial asthma** with **cortisone** is described by Gelfand (*N. Eng. J. Med.* 245:293 [Aug. 23] 1951). He dissolved 25 mg. of cortone in 5 cc. of saline and gave 1 cc. of this mixture by aerosol every hour for 10 hours daily. After such treatment the patients were probably tired, but happy.

The usual vasodilating agents (alcohol, body-warming, tetraethylammonium chloride, and Priscoline) produce an increase in peripheral (foot) blood flow equal to only half that following lumbar paravertebral block. The newest dilator, **Hexamethonium** (C6) produces effects *equal* to paravertebral block. Finnerty and Freis were very favorably impressed with its action in 29 patients with **peripheral vascular disease** in whom they tried it. Relief in Buerger's, Raynaud's, causalgia and arteriosclerosis obliterans was obtained with hypo doses of 50 mg. and oral doses of 1.5 gms. C6 has prolonged action (6-12 hours) and the only drawback is postural hypotension. (*N. Eng. J. Med.* 245:325 [Aug. 30] 1951.)

**Benemid**, the renal blocking agent so effective in elevating serum levels of penicillin and PAS, seems to have an opposite effect on uric acid. Accelerated **uric acid excretion** is reported in both normal and gouty patients by Bishop, et al. (*J. Clin. Invest.* 30:889 [Aug.] 1951.)

C. A. DOMZALSKI, JR., M.D.



# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*  
 MRS. MARTHA WEBER, *Assistant Librarian*  
 Phone 65370  
 8:00 a.m.-4:30 p.m., and 7:30 p.m.—9:30 p.m.  
 Monday through Friday  
 Closed Saturdays at noon and Sundays  
 Closed all day and evening on National holidays  
 and at noon on Territorial holidays

## RECENT ACQUISITIONS

### Biochemistry

- Harper, H. A. *Review of physiological chemistry*. 3rd ed. c1951. (gift of publisher)  
 Luck, J. M., ed. *Annual review of biochemistry*. v.20. 1951.

### Cancer

- Berman, Charles. *Primary carcinoma of the liver*. 1951.

### Diagnosis

- Brust, R. W. *Physical diagnosis*. c1951. (gift of publisher)

### Electrocardiography

- Lipman, B. S. *Clinical unipolar electrocardiography*. c1951. (gift of publisher)

### Genito-Urinary System

- Allen, A. C. *The kidney*. c1951. (gift of publisher)  
 Narath, P. A. *Renal pelvis and ureter*. c1951. (gift of publisher)

### Gynecology and Obstetrics

- Kosmak, G. W., ed. *Transactions of the International and Fourth American Congress on Obstetrics and Gynecology*. c1951. (gift of publisher)

### Hematology

- Moore, C. V., ed. *Proceedings of the Third International Congress of the International Society of Hematology*. c1951. (gift of publisher)

### Mental Hygiene

- Maas, H. S., ed. *Adventure in mental health*. c1951. (gift of publisher)

### Ophthalmology

- Keeney, A. H. *Chronology of ophthalmic development*. c1951. (gift of publisher)

### Orthopedics

- American Academy of Orthopedic Surgeons. *Instructional course lectures*. v.8. 1951.  
 Key, J. A. *The management of fractures, dislocations and sprains*. c1951. (gift of publisher)

### Pediatrics

- Reynolds, M. M. *Children from seed to saplings*. 2nd ed. c1951. (gift of publisher)

### Peripheral Vascular Diseases

- Heymans, Corneille. *Introduction to the regulation of blood pressure and heart rate*. c1951. (gift of publisher)  
 Marple, C. D. *Thromboembolic conditions and their treatment with anticoagulants*. c1951. (gift of publisher)  
 Roth, G. M. *Tobacco and the cardiovascular system*. c1951. (gift of publisher)  
 Spitzer, Alexander. *The architecture of normal and malformed hearts*. c1951. (gift of publisher)

### Therapeutics

- Mennell, J. B. *Manual therapy*. c1951. (gift of publisher)

### Tropical Medicine

- Gradwohl, R. B. H. *Clinical tropical medicine*. c1951. (gift of publisher)

### Tuberculosis

- National Tuberculosis Association. *Tuberculosis hospital and sanatorium directory*. c1951. (gift of N. T. A.)

### Tumors

- Karsner, H. T. *Tumors of the adrenal*. (Sect. 8, Fasc. 29, Atlas of Tumor Pathology.) 1950. (gift of Armed Forces Institute of Pathology)  
 Stout, A. P. *Tumors of the peripheral nervous system*. (Sect. 2, Fasc. 6, Atlas of Tumor Pathology.) 1949. (gift of Armed Forces Institute of Pathology)

### Miscellaneous

- Akana, Akaiko, trans. *Hawaiian herbs of medicinal value*. 1922.  
 A.M.A. Council on Pharmacy and Chemistry. *New and non-official remedies*. 1951.  
 Brown, A. L. *Technical methods for the technician*. 4th ed. 1951. (gift of author)  
*Quarterly Cumulative Index Medicus*. v.47. Jan.-June 1950.  
 Tead, Ordway. *The art of administration*. c1951. (gift of publisher)  
 Youmans, J. B., ed. *Medicine of the year*. 1951. c1951. (gift of publisher)

The following list of books purchased for the Library by the Board of Medical Examiners is supplementary to the one published in the September-October issue of the Journal. This collection has already had wide circulation, and doctors and nurses who have used these books have expressed to us their gratitude. We wish to pass their—and our—acknowledgments on to the Board.

- Sweet, R. H. *Thoracic surgery*. c1950.  
 Overholser, Winifred. *Handbook of psychiatry*. c1947.  
 Strecker, E. A. *Fundamentals of psychiatry*. 4th ed. c1947.  
 Cole, W. H., ed. *Operative technic in specialty surgery*. c1949.

- Cole, W. H., ed. *Operative technic in general surgery*. c1949.
- Maingot, Rodney. *Abdominal operations*. 2nd ed. c1948.
- Kolmer, J. A. *Clinical diagnosis by laboratory examinations*. 2nd ed. c1948.
- U. S. Naval Medical School. *Color atlas of pathology*. n.d.
- Anderson, W. A. D., ed. *Pathology*. c1948.
- Meleney, F. L. *Clinical aspects and treatment of surgical infections*. c1949.
- Regan, L. J. *Doctor and patient and the law*. 2nd ed. c1949.
- Maximow, A. A. *A textbook of histology*. 5th ed. c1948.
- Gray, Henry. *Anatomy of the human body*. 25th ed. c1948.
- Burch, G. E. *A primer of electrocardiography*. 2nd ed. rev. c1949.
- Cozen, Lewis. *Office orthopedics*. c1950.
- Boyd, William. *A textbook of pathology*. 5th ed. rev. c1947.
- Boyd, William. *Surgical pathology*. 6th ed. c1947.
- Faulkner, R. L. *Essentials of obstetrical and gynecological pathology*. c1949.
- Harrison, T. R., ed. *Principles of internal medicine*. c1950.
- Pullen, R. L., ed. *Medical diagnosis*. 2nd ed. c1950.
- Bastedo, W. A. *Pharmacology, therapeutics and prescription writing*. c1947.
- Hawley, E. E. *The art and science of nutrition*. 3rd ed. c1949.
- Hawk, P. B. *Practical physiological chemistry*. 12th ed. c1947.
- Cheney, Garnett. *Medical management of gastrointestinal disorders*. c1950.
- Brown, J. B. *Skin grafting*. 2nd ed. c1949.
- Foot, N. C. *Identification of tumors*. c1948.
- Adriani, John. *Techniques and procedures of anesthesia*. c1947.
- Sodeman, W. A., ed. *Pathologic physiology*. c1950.
- McCormick, C. O. *A textbook on pathology of labor, the puerperium and the newborn*. 2nd ed. c1947.
- Schaub, I. G. *Diagnostic bacteriology*. 3rd ed. c1947.
- Rice, T. B. *A textbook of bacteriology*. 4th ed. c1947.
- Janney, J. C. *Medical gynecology*. 2nd ed. c1950.
- Cantarow, Abraham. *Clinical biochemistry*. 4th ed. c1949.
- Lever, W. F. *Histopathology of the skin*. c1949.
- Geschickter, C. F. *Tumors of bone*. 3rd ed. c1949.
- Wangensteen, O. H. *Intestinal obstructions*. 2nd ed. c1942.
- Stieglitz, E. J., ed. *Geriatric medicine*. 2nd ed. c1949.
- Sutton, R. L. *Handbook of diseases of the skin*. c1949.
- Davison, F. R. *Handbook of materia medica, toxicology and pharmacology*. 4th ed. c1949.
- Meakins, J. C. *Symptoms in diagnosis*. c 1948.
- Titus, Paul. *The management of obstetric difficulties*. 4th ed. c1950.
- Karsner, H. T. *Human pathology*. 7th ed. c1949.
- Bell, E. T. *A textbook of pathology*. 6th ed. rev. c1947.
- Reich, W. J. *Practical gynecology*. c1950.
- Thewlis, M. W. *The care of the aged*. 5th ed. rev. c1946.
- Cecil, R. L., ed. *A textbook of medicine*. 8th ed. c1951.
- Geschickter, C. F. *Diseases of the breast*. 2nd ed. c1945.
- Magnuson, P. B. *Fractures*. 5th ed. c1949.
- Kleiner, I. S. *Human biochemistry*. 2nd ed. c1948.
- Ackerman, L. V. *Cancer*. c1947.
- Fulton, J. F., ed. *A textbook of physiology*. 16th ed. c1949.
- Behrens, C. F., ed. *Atomic medicine*. c1949.
- Curtis, A. H. *A textbook of gynecology*. 6th ed. c1950.
- Anson, B. J., *An atlas of human anatomy*. c1950.
- Pullen, R. L., ed. *Communicable diseases*. c1950.
- Lull, C. B. *Control of pain in childbirth*. 3rd ed. rev. c1948.
- Lichtenstein, B. W. *A textbook of neuropathology*. c1949.
- Christopher, Frederick. *Minor surgery*. 6th ed. c1948.
- Rubin, E. H. *Diseases of the chest*. c1947.
- Callander, C. L. *Surgical anatomy*. 2nd ed. rev. c1948.
- Sunderman, F. W. *Normal values in clinical medicine*. c1949.
- Duncan, G. G., ed. *Diseases of metabolism*. 2nd ed. c1947.
- Fine, Jacob. *Care of the surgical patient*. c1949.
- Novak, Emil. *Gynecological and obstetrical pathology*. 2nd ed. c1947.
- Christopher, Frederick. *A textbook of surgery*. 5th ed. c1949.
- Williams, R. H., ed. *Textbook of endocrinology*. c1950.
- Eastman, N. J. *Williams Obstetrics*. 10th ed. c1950.
- Bunnell, Sterling. *Surgery of the hand*. 2nd ed. c1948.
- Ferguson, L. K. *Surgery of the ambulatory patient*. 2nd ed. c1947.
- White, B. V. *Diagnosis in daily practice*. c1947.
- Saul, L. V. *Basis of human behavior*. c1951.

Dr. Richardson of San Francisco, who flew to Honolulu to operate on George Vanderbilt, visited the Library several times. He was most complimentary about the collection, and told us that he would "like to stay for a week and do nothing but study in your library."



# BOOK REVIEWS

---

## **Technical Methods for the Technician.**

By Anson Lee Brown, B.A., M.D., Fourth Edition, 784 pp. Price \$10.00. Anson Lee Brown, Inc., 1951.

This is primarily a book for beginners in the field. It brings up a number of very simple questions which tend to help the novice. It describes tests, cook book style, but discusses little of the principles and stumbling blocks present. For the graduate technician its value is chiefly in that it lists the procedures in many tests and has tried to maintain latest terminology. The book certainly must be used only in conjunction with more detailed and more basic texts. Used in this way it has value for the technician.

The book has a practical binding and the print is clear. Some color plates are present and a fair number of black and white pictures and diagrammatic representations are also included.

W. HAROLD CIVIN, M.D.

## **Causalgia.**

By Frank H. Mayfield, M.D., 65 pp. with illustrations. Price \$2.25. Charles C. Thomas, 1951.

A very concentrated and meaty monograph beginning with a short history of the evolution of our present concepts of definition and treatment of causalgia. The author specifically defines what he means by causalgia and limits his case histories to these specific type cases only.

In my opinion this is a well written monograph and worth the time and effort one would spend to refresh himself on peripheral nerve injuries.

WM. M. WALSH, M.D.

## **The Management of Fractures, Dislocations, and Sprains.**

By John Albert Key, B.S., M.D. and H. Earle Conwell, M.D., F.A.C.S., Fifth Edition, 1232 pp. with illustrations. Price \$16.00. C. V. Mosby Company, 1951.

Drs. Key and Conwell have again edited an excellent book on fractures, dislocations and sprains. This edition has fewer pages than the previous edition which is certainly a step in the right direction. The printing and binding of this book is excellent.

The authors cover their subject very well and completely. The material covered included many new ideas and re-evaluation of the old methods. Considerable emphasis is placed on methods of treatment that can be of considerable value to the general practitioner.

Since the possibility of malpractice suits in fracture cases is much greater today, the chapter on "Medico-legal Aspects in Fracture Cases" is invaluable. Also an excellent chapter on the subject of workmen's compensation laws has been included. The general practitioner as well the specialist can find much of value in this fifth edition.

B. ALLEN RICHARDSON, M.D.

## **Review of Physiological Chemistry.**

By Harold A. Harper, Ph.D., Third Edition, 260 pp. Price \$3.50. University Medical Publishers, Palo Alto, California, 1951.

This is an excellent manual for a quick review, summary, or reference concerning the more general aspects of physiological chemistry in their relationship to medicine. The latest concepts are all clearly presented. No great mass of detail is resorted to, and the charts and tables are easily followed. There are quite a few formulas but these can be easily overlooked if one is not interested in them.

The physical aspects of the book are not elaborate. The cover is cardboard and the binding is plastic. The print is moderately large and is legible.

This is really the best physiological chemistry reference that I know for the practitioner of medicine.

W. HAROLD CIVIN, M.D.

## **The Regulation of Blood Pressure and Heart Rate.**

By Corneille Heymans, M.D., 60 pp. Price \$2.00. Charles C. Thomas, 1950.

This is a concentrated treatise on the physiology of the vascular system. The author has drawn heavily on contemporary literature and has used diagrams freely throughout. Much of the material is reminiscent of medical school sophomore physiology. The material is well organized, and it should be considered primarily as a book for those who wish to intensively review their physiology of the vascular system. Despite the fact that it is not a long treatise, the material is so meaty that it cannot be skimmed through quickly.

For those physicians who wish to review some of the important physiological mechanisms of the vascular system I would recommend this monograph. It is not a substitute for the chapters on vascular physiology in Best and Taylor, but there is enough material to make it worthwhile, particularly from the standpoint of being up-to-date.

MORTON E. BERK, M.D.

## **Pulmonary Ventilation and Its Physiological Regulation.**

By John S. Gray, M.D., Ph.D. 82 pp. Price \$2.00. Charles C. Thomas, Publisher, Springfield, Illinois, 1950.

This brief monograph gives an excellent description of the physiological mechanisms governing respiration. The author shows clearly that oxygen is strongly contraindicated in morphine and barbiturate poisonings. He then progresses into a highly technical description of the details of the mechanisms of pulmonary ventilation. This book is of considerable value for the expert in the field of respiratory physiology, but leaves the novice considerably bewildered at the complex formulas used in the calculations.

RAYMOND M. DEHAY, M.D.

**Clinical Unipolar Electrocardiography.**

By Bernard S. Lipman, A.B., M.D. and Edward Massie, A.B., M.D., FACP., 232 pp. Price \$5.00. Year Book Publishers, Inc., 1951.

By the use of understandable application of electrophysiologic principles, numerous sketches and a thoroughly readable text, the authors have produced an excellent manual of clinical electrocardiography.

Although there are 91 clear reproductions of unipolar electrocardiographs at the end of the text, there is fortunately no encouragement for either the novice or experienced electrocardiographer to approach this field by memorizing characteristic patterns.

It is recommended to all who interpret electrocardiograms and especially those who have not recently reviewed the advantages of unipolar techniques.

FRED I. GILBERT, JR., M.D.

**The Odyssey of Modern Drug Research.**

By Robert Burlingham, 124 pp. Price, free. Upjohn Company, 1951.

This enthralling account of how the pharmaceutical houses ply their trade in the twentieth century, written by a former associate editor of *Fortune*, is well worth the time it takes to read it. It is astonishing, and highly refreshing, to note the frequent complimentary references to enterprises of competing pharmaceutical firms, stories of their accomplishments and sacrifices, told side by side with, and with just as much emphasis as that accorded to, Upjohn's own. From this point of view the book is an admirable example of good public relations. From any point of view it is fascinating reading.

Bound only in heavy paper, the book is printed in clear large type on glossy paper with wide margins; it is profusely illustrated in color. If you haven't seen it, by all means ask the local representative for a copy of your own.

HARRY L. ARNOLD, JR., M.D.

**Handbook of Pediatric Medical Emergencies.**

By Adolph G. DeSanctis, M.D. and Charles Varga, M.D., 285 pp. with 51 illustrations. Price \$5.00. C. V. Mosby Co., 1951.

Originally intended as a guide for members of the resident staff, this handbook has been revised and enlarged for the benefit of practitioners, who must frequently administer rapid, emergency therapy to various conditions encountered in pediatric practice. Here in 1-2-3 fashion are given outlines of treatment for such conditions as acute diarrhea, convulsions, croup, and accidental injuries and poisoning. Although one may not agree completely with the methods of therapy as outlined, this book furnishes a quick reference text; modifications in therapy for each individual patient may be made therefrom. It is felt, therefore, that this little book has a place in the library of a busy clinician, within easy reach.

JOHN T. KOMETANI, M.D.

**Manual Therapy.**

By James B. Mennell, M.D., 64 pp. Price \$2.25. Charles C. Thomas, 1951.

Dr. Mennell gives a brief history of massage and manual therapy, and feels introduction of Swedish massage and gymnastics was first step in establishing physical medicine, but it was exploited and, due to false statements as to results of massage, its use was neglected. He explains how one must apply physiological laws to all forms of physical treatments. He gives types of massage treatments, cupping, techniques, administration, dosage and desired results in descriptive detail, and a detailed explanation of passive, assistive and resistive movements as to range of motion and positions in which to get best results.

Joint manipulation is fully explained with descriptive pictures and discussions of method used. In joint manipulations all movements should follow the law of living anatomical and physiological movement.

ELEANOR H. HANSEN, R.N., P.T.A.

**Adventure in Mental Health.**

Edited by Henry S. Maas, Ph.D., 334 pp. Price \$4.50. Columbia University Press, 1951.

This book on mental health, written in simple understandable language, is a compilation of the experiences of 16 psychiatric social workers who have completely covered the subject in its relationship, functions and need, in the military setting in World War II. It is of extreme value to those in the profession who may be anticipating a military career and should be part of their armamentarium.

CAPT. M. SHUPP, M.C., U.S.N.

**Tobacco and the Cardiovascular System.**

By Grace M. Roth, Ph.D. 66 pages. Price \$2.25. Publication No. 100 of the American Lecture Series of Medical Monographs. Charles C. Thomas, 1951.

Here is all you could want to know about the vasoconstriction and tachycardia produced in normal persons by smoking, except perhaps an answer to the question of whether an exciting movie or whodunit produces about the same effect. The literature is reviewed in detail (72 references) and a number of original experiments are reported, with charts and graphs. Thackeray's "amiable anodyne" is reduced to millimeters of mercury, degrees Centigrade, and pulsations per minute. The tone is much more objective and dispassionate than is usual in works of this sort—apparently most of the people who investigate tobacco don't approve of its use—but the author does believe, apparently, that the effects she describes are harmful ones and tend to shorten life somewhat. Noteworthy is the quotation from Mark Twain to the effect that giving up smoking was the easiest thing he ever did—and he ought to know, he added, because he'd done it a thousand times!

HARRY L. ARNOLD, JR., M.D.



# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 312th regular meeting of the Hawaii County Medical Society was called to order by **President T. David Woo** at 7:45 p.m., Thursday, September 27, 1951 in the staff-room of Hilo Memorial Hospital. Guests present were **Major M. D. Boyd**, **Col. William Boyen** of the Selective Service Board; **Dr. J. S. Kuger** of Kilauea Military Camp, **Dr. R. Kaufmann**, and **Dr. H. Irwin**.

The Society was notified of the application for membership of **Dr. Robert J. Kaufmann** of Pahala, Kau, Hawaii. The application will be referred to the Board of Censors and final action will be taken at the next regular meeting of the Society.

A copy of the letter from the Hawaii Territorial Medical Association to the Woman's Auxiliary to the Hawaii County Medical Society in regards to helping with radio advertisements and playing records against socialized medicine and the refilling of health literature in racks in doctors' offices was read. After a short discussion it was moved by **Dr. H. E. Crawford**, and seconded by **Dr. R. Miyamoto**, that we sanction the use of the recordings over the radio, but before any expenses are involved, we would like to know details concerning such a program. This motion was passed unanimously. The Woman's Auxiliary will be notified of this action.

**President Woo** announced that there is now available a Speech Training Center in Hilo located at the Hilo Intermediate School under the direction of Miss Hang Fa Elaine Wong and suggested that the doctors may make use of the services of Miss Wong.

The question of moving the Library from Hilo Memorial Hospital to Puuamale Hospital was again brought up for discussion since opinions of most of the members have changed since the last meeting. After a short discussion it was moved by **Dr. R. Miyamoto** and seconded by **Dr. H. E. Crawford** that the library be moved to Puuamale Hospital when feasible. This motion was passed unanimously. **Dr. S. Mizuire** stated that the Cancer Society will give \$100 to be used for subscriptions to the Cancer Journal and other journals relating to cancer.

**Dr. H. E. Crawford** gave a brief over-all picture as to what is going on and what is planned for Civilian Defense. However, he stated that there is no over-all plan as yet.

**Dr. S. Mizuire** explained what has been going on concerning the blood emergency program and stated that there has been created a Territorial Blood Committee. He also stated that the Blood Bank of Hawaii has been taking the lead by forming an Emergency Blood Bank located in Honolulu, T. H. He also added that technicians will be trained and that Hilo will send 16 for training . . . 4 at a time for a period of 2 weeks. This will start on October 1, 1951. The trainees will be paid \$200 for the two weeks training period. Those trained will be expected to work everytime the blood bank team comes over to Hilo.

**Major Boyd** of Tripler Army Hospital then gave a talk on the Medical Aspects of the Selective Service.

He stated that one of the greatest problems is giving physical examinations (and consultations) to the inductees on the outside islands since sending all inductees to Honolulu for examination has cost the government large sums of money. He asked for suggestions from the members of the local Society.

FRANCIS F. C. WONG, M.D.  
Secretary

## HONOLULU COUNTY MEDICAL SOCIETY

The September meeting of the Society was held on September 7, 1951 at 7:30 p.m., in the Mabel Smyth Auditorium with **Dr. John Devereux** presiding and approximately 115 members and guests present.

An interesting program entitled "What is Your Health Department Doing?" was presented.

**Dr. C. L. Wilbar**, moderator, described the work of the Division of Preventive Medicine in which there are the following seven bureaus: Epidemiology, Laboratories, Maternal and Child Health and Crippled Children, Mental Hygiene, Nutrition, Tuberculosis, and Venereal Diseases and Cancer Control.

**Mr. B. J. McMorrow**, Director of the Division of Sanitation, spoke on the work of his division. **Mr. M. A. Taff**, Chief, Bureau of Health Statistics, presented the highlights of his work as they concern the physicians. **Miss Laura Draper**, Chief of the Bureau of Public Health Nursing, outlined the work of the public health nurse. **Dr. E. K. Chung-Hoon** described the Hansen's disease program. **Dr. Leo Bernstein** discussed the program of the Division of Hospitals and Medical Care.

**Dr. Dan Gordon**, ophthalmologist and Assistant Professor of Clinical Surgery at Cornell University, spoke on the use of ACTH and cortisone in eye diseases.

**Dr. Samuel J. Glass**, of the Department of Endocrinology of the Cedars of Lebanon Hospital in Los Angeles, described the influence of the liver on sex endocrine functions.

Meeting adjourned at 10:30 p.m. to refreshments on the lanai.

A dinner meeting of the Society was held on October 5, 1951, 7:30 p.m. at the Oahu Country Club with **Dr. John Devereux** presiding and approximately 145 members and guests present.

In accordance with the provisions set forth in the Constitution and By-Laws regarding amendments, it was unanimously voted that associate membership dues be increased from \$5.00 to \$10.00 yearly, effective January 1, 1952.

**Dr. F. J. Pinkerton**, President of the Pan-Pacific Surgical Association, requested that physicians "turn out" to make the Pan-Pacific Surgical Congress a great success.

**Dr. Devereux** announced that on Wednesday evening, October 17, the Medical Society and the Society of Sigma Xi are co-sponsoring a lecture honoring **Sir Edward Mellanby** of London, England, former Secretary of the British Medical Research Council. "The Effect

of Vitamins A and D on Bones and the Nervous System" will be discussed by Dr. Mellanby.

An interesting nonscientific program was prepared for the meeting.

- 1. *Investments for Doctors*—**Mr. George H. Kellerman**, Vice President and Manager, Stocks and Bonds Department, Bishop Trust Company, Ltd.
- 2. *Doctors' Tax Dilemma* — **Mr. James H. Anthony**, Assistant Treasurer and Manager, Tax Department, Bishop Trust Company, Ltd.
- 3. *Malpractice*—**Mr. Thomas M. Waddoups**, President, Territory of Hawaii Bar Association.

A vigorous question and answer period followed the above outlined program.

WILLIAM S. ITO, M.D.  
*Secretary*

KAUAI COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital at 7:30 p.m. on Wednesday, September 12, 1951 with **Dr. Fujii** presiding.

The minutes of the previous meeting were read and approved.

**Dr. Peter Kim's** application for membership to the Society was read and it was moved and seconded that he be accepted into the Society. A prorated fee of \$5.00 was promised the Society by Dr. Kim.

The amendment to the By-Laws regarding military status has been withdrawn by **Dr. Wade** after his careful perusal of present, past, and other existing Constitutions and By-Laws.

A lengthy discussion followed on immunization for typhoid and tetanus, particularly on the subject of fees. It was the majority's opinion that the fee for this service should be left to the individual physician.

**Dr. Lawrence Wiig's** letter to **Dr. Wallis** concerning mainland speaker or speakers to be available in early winter following the Pan-Pacific Surgical Conference was studied. The program was heartily accepted by the Society and Dr. Wallis was asked to contact Dr. Wiig for arrangement.

Communication from **Dr. Fujii** to **Mr. Charles Fern** was presented. It consisted of **Dr. C. L. Wilbar's** request for assistance to send **Dr. Dorothy Kemp** for further Board of Health studies. The Society went on record in support of this worthy request.

**Dr. Harrington** of the Mayo Clinic will be available after the Pan-Pacific Surgical Conference. It was suggested that he be invited to talk to the Society.

Three films titled "Subtotal Gastrectomy" and one titled "Surgical Treatment of Pyloric Hypertrophy" were shown.

CLYDE H. ISHII, M.D.  
*Secretary*

MAUI COUNTY MEDICAL SOCIETY

Regular meeting of the Maui County Medical Society was called to order by **President Dr. E. Shimokawa** at 3:00 p.m. on Tuesday, August 21, 1951, at the Grand

Hotel. Guests present were: **Dr. John Bell** and **Dr. Thomas T. Tennant**.

A brief scientific meeting preceded the business portion. **Dr. John Bell**, heart specialist and member of the Hawaii Heart Association, was guest speaker. He spoke briefly on heart conditions in general and stressed the value of ACTH in critical cases of rheumatic fever.

Members expressed the feeling that a temporary pathologist working out of Honolulu was not satisfactory. A letter was received from **Dr. A. Y. Wong** asking for further clarification of the possibility of obtaining a pathologist. After a lengthy discussion, motion was made, seconded, and unanimously carried, that the Pathology Committee of which **Dr. St. Sure** is chairman, be instructed to immediately contact a physician on the mainland and present a report of our present needs, conditions, facilities, salary, etc. Conditions are to be based on an agreement made by the Cancer Society and the Maui hospitals, namely, Malulani Hospital, Kula Sanatorium and Kula General Hospital, Pioneer Mill Hospital, and Puunene Hospital.

A letter of resignation from **Dr. Vernon K. S. Jim** was read and approved.

A letter from **Dr. F. K. Lam** was read. It included leaflets, posters and instructions on the Immunization Program, which were distributed by **Dr. Lathrop**. On motion duly made, seconded and carried, it was agreed to charge \$1.00 per injection. A letter expressing approval of such a program will be written.

**Dr. L. W. Harrington** of the Mayo Clinic will come to Maui in November 1951. **Dr. McArthur** was asked to accept his offer to talk to the Society.

Indigent Cases: **Dr. Patterson** stressed the point that private physicians give free services to indigents. It was moved that the Medical Society appoint a committee to study the care of indigents, especially on specialist's care, i.e., for operations, special treatments, etc. President appointed **Dr. A. Y. Wong**, chairman; **Dr. E. Tompkins**, **Dr. Ed. Underwood**, **Dr. Wm. Toney**, **Dr. A. L. Burden**, members, and **Dr. T. G. Lathrop**, advisor.

✓   ✓   ✓

The regular meeting of the Maui County Medical Society was held at the Maui Grand Hotel on Tuesday, September 18, 1951, with **Dr. E. Shimokawa** presiding. Guests present were: **Major Maxwell D. Boyd**, **Colonel Boyen** of Tripler Army Hospital, and **Mr. Taff** of the Department of Health, Bureau of Statistics.

**Major Boyd** spoke on the possibility of Maui doctors examining Maui inductees to the Army. After much discussion, Maui doctors felt that as far as physical examination was concerned, the doctors were willing to do their share. It was understood that the laboratory work and clerical work would be supplied by the Army. **Colonel Boyen** spoke briefly to substantiate what Major Boyd had said previously. **Dr. Fleming** made a motion to do all the physical examinations for the inductees free of charge. Motion was seconded by **Dr. St. Sure** and unanimously carried.

EDWARD S. KUSHI, M.D.  
*Secretary*



# NOTES AND NEWS

## PERSONALS

**Dr. Angie Connor**, acting chief of the Bureaus of Maternal and Child Health, and Crippled Children, of the Territorial Department of Health, left for a year's graduate study at the University of California. Dr. Connor will pursue further work in Public Health on a fellowship awarded by the National Foundation for Infantile Paralysis.

**Dr. Joseph T. Y. Kam** has announced the opening of his offices for the private practice in dermatology and syphilology. Dr. Kam was graduated from St. Louis College in 1932 and Santo Tomas Medical College in 1941. He received his graduate training at Lakeside University Hospital in Cleveland. Prior to his return to Honolulu, he was chief dermatologist and syphilologist at the Nanking Central Hospital, Nanking, China, and during the past year, assistant resident physician at Kalaupapa Settlement.

**Dr. Joseph Palma** of the Pediatric Department of The Clinic has returned from a short trip to the mainland. While away, Dr. Palma entered his daughter, Joan, at Kingswood School, Cranbrook, Michigan.

Back at his desk from a trip to Manila is **Dr. Charles Wilbar**, President of the Territorial Department of Health. Dr. Wilbar represented the U. S. as a technical observer at the meeting of the Western Pacific Region of the World Health Organization.

**Dr. Edgar Childs**, accompanied by his family, left for an extended study tour for Philadelphia. While away, Dr. Childs will take postgraduate work in roentgenology.

Continuing the practice of medicine at Dr. Childs' former office, but limiting himself to internal medicine, is **Dr. Chew Mung Lum**. Dr. Lum is a graduate of Northwestern University Medical School. He has had advanced training at Wesley Hospital and more recently at Queen's Hospital.

**Dr. B. Allen Richardson** has been appointed as part time medical consultant to the Department of Public Welfare.

Guest speakers at a recent meeting of the Honolulu Surgical Society were **Colonel L. K. Mantell**, Chief of the Urological Service; **Lt. Col. H. F. Bertram**, Assistant Chief of the Surgical Service, and **Major Benjamin Musser**, Chief Resident of the Surgical Service, of Tripler Army Hospital.

Also announcing the opening of an office for the general practice of medicine and surgery is **Dr. Edmund C. K. Lum**. Dr. Lum is a graduate of Northwestern University Medical School and served his internship at Cook County Hospital, Chicago.

Death has claimed three of Hawaii's kamaaina physicians:

**Dr. Tai Heong Kong Li**, Honolulu's first Chinese woman physician and wife of Dr. Khai Fai Li, died on August 11. Dr. Li, mother of **Dr. Min Hin Li**, **Dr. Elizabeth Li**, **Mrs. Richard Sia** and five other children had been in active practice for 53 years prior to her retirement in 1949.

**Dr. Tokue Takahashi**, a long time Honolulu physician, died in Tokyo on September 5.

**Dr. J. A. Morgan**, distinguished Honolulu eye, ear, nose, and throat surgeon, passed away on September 25. Dr. Morgan had been in ill health for the past four years and was confined to his home for the past two years.

Our deepest sympathies to the families of our colleagues.

**Dr. and Mrs. K. B. Chun** are the parents of a son born August 22.

**Dr. Alfred S. Hartwell** addressed the Rotary Club of Honolulu. The title of his address was "A Heart to Heart Talk."

**Dr. Matsuju Yamashiro** returned from Okinawa after a 3 months' visit. As a representative of the Okinawa Medical Relief Society, Dr. Yamashiro and three other local Okinawan leaders took \$15,000.00 worth of medical supplies to Okinawa.

Joining the local ophthlmo-oto-rhino-laryngologists is **Dr. Phillip W. H. Chock**. Dr. Chock is a graduate of Hilo High School, the University of Kansas and Rush Medical School. He interned at the Holy Cross and Cook County Hospitals and received his postgraduate training at the Illinois Eye and Ear Infirmary in Chicago. His new office is in the National Building, Honolulu.

Back from a postgraduate course at Margaret Hague Hospital for Women in New Jersey is **Dr. Lucy Ma Fong**.

**Dr. Francis K. Chu** has recently opened his office at Nuuanu Square Building. Dr. Chu, a pediatrician, graduated from Marquette University Medical School. He interned at St. Louis University Hospital and had a medical residency at Queen's. He received his advanced training at White Memorial, Los Angeles County General and Queen of Angels Hospitals, all in Los Angeles.

**Dr. Stephen M. K. Hu**, Chief of the Mosquito Control Bureau, has returned from the first worldwide conference on filariasis in Papeete, Tahiti. He also visited the Fiji Islands, and British Samoa.

**Dr. Albert Lemes**, dentist, was elected President of the Territorial Dental Society.

**Dr. Harry L. Arnold, Jr.**, addressed the Engineering Association of Hawaii on the subject of socialized medicine.

**Dr. Edwin Willett** has been named plantation physician at the Hutchinson Sugar Plantation Company at Naa-lehu, Hawaii. Dr. Willett is a graduate of Punahou, Washington State College and George Washington University. He served his internship at the Naval Medical Centre, Bethesda, Maryland.

**Dr. Hastings H. Walker**, director of Leahi Hospital, celebrated his 27th year anniversary of service with the hospital. The occasion was coincidental with the dedication of a new million dollar unit at Leahi.

**Kent W. Longnecker**, popular and able administrator of Kapiolani Hospital, has accepted a position as Assistant Business Administrator of Leahi Hospital, beginning January 1, 1952. Mr. Longnecker is a graduate of the Hotel Administration course at Cornell University and the course for Hospital Administration at Northwestern University. He will be missed from Kapiolani, and his many friends wish him well in his new undertaking.

## Hawaii

Not much News and Notes from Hawaii this time. I understand **Dr. Sam Brown** was on the mainland for about a week. Of course, he is back.

**Dr. and Mrs. Archie Orenstein** are vacationing on the mainland. They are expected back late in December. In the meantime, **Dr. M. A. Glover**, the only woman doctor on this island, is substituting for Dr. Orenstein.

**Dr. Clyde Phillips** is still on the mainland for his health. We all hope that he is better and will be back soon.

Oh yes, let me introduce **Dr. Edward Wong** who started his practice in pediatrics at 472 Kamehameha Ave., Hilo, Hawaii. He is a graduate of St. John's University, Shanghai, China in 1942. He served his internship at St. Luke's Hospital, Shanghai, China. To top it all, he was a prisoner of war from 1941 to 1944. He escaped from the Japanese in January, 1944, and joined the U. S. 14th Air Force until the termination of hostilities. He returned to the U. S. and took postgraduate studies in Pediatrics at the University of Pennsylvania. He served yearly residencies in Pediatrics at Sea View

Hospital, N. Y., St. Vincent's Hospital, N. Y., and Children's Memorial Hospital in Chicago, Ill. He is single.

## Maui

**Dr. Edmund Tompkins**, superintendent of Kula Sanatorium, attended the meeting of the American Hospital Association which met in St. Louis in September. He also spent some time visiting in Oregon, and returned home the latter part of October.

**Dr. Lester Kashiwa** recently left to assume a residency in Proctology at Jefferson Medical College Hospital in Philadelphia.

**Dr. Vernon Jim** and family, who left early in the summer, are now living in Chicago. Dr. Jim is taking a postgraduate course in ophthalmology at Billings Hospital in that city.

**Dr. Harold Kushi** recently spent three months in advanced ophthalmology study in Maine.

**Dr. and Mrs. Joseph Ferkany** of Kula visited relatives in Pittsburgh following the meeting of the American Surgical Association in Washington, D.C., which Dr. Ferkany attended.

# UMI MAKAHIKI I HALA\*

**Dr. John Moorhead** of New York City has accepted the invitation of the Honolulu County Medical Society to come to Hawaii for a series of postgraduate lectures on traumatology. He arrives on December 3. The lecture topics and dates will be publicized later.

**Dr. Louis L. Buzaid** is the new full-time radiologist at Queen's Hospital, and director of its X-ray Department. His services are available to all members of the staff for discussion of cases.

**Dr. N. R. Sloan** has been appointed to take **Dr. I. D. Hirschy's** place as resident physician in charge of Kalau-papa Leprosy Settlement, during the latter's leave of absence on the mainland. Dr. Sloan has been assisting Dr. Hirschy since last July, and has recently been licensed to practice medicine in the Territory.

**Dr. and Mrs. Ralph B. Cloward** recently announced the birth of their second daughter, Karen. Dr. Cloward has left by Clipper for Los Angeles to attend the meeting of the American Academy of Neurological Surgery, to which he was recently elected.

The entire Territory was recently honored in the person of **Dr. F. J. Pinkerton** by his election to the Vice-presidency of the American Academy of Ophthalmology and Otolaryngology.

**Dr. O. E. Jeffreys** has left Honolulu and is at present in Los Angeles.

**Dr. Fred Irwin**, retired, has been with the Hawaii Medical Service Association for the past year as medical director, and has been doing an excellent piece of work.

Our first exchange subscription is with *Pennsylvania Medical Journal*. Dr. Donaldson, the Editor, writes: "Wishing the Hawaii Medical Journal great success and its editorial staff increasing satisfaction with the results of their labors, we hasten to add your 'baby' to our Exchange list."

Since the report on Medical Preparedness published in the first number of the JOURNAL, several interesting developments have occurred. One was the decision of the Major Disaster Council to appoint **Dr. H. L. Arnold** as a member of the Executive Committee of the Council in charge of first aid units and ambulance service. He selected as his advisory committee, the Preparedness Committee elected by the Honolulu County Medical Society, and as his executive officer, **Dr. Robert Faus**, now a Major in the Medical Corps of the Army. The Disaster Council at the same time decided that the program for hospital expansion and possible evacuation should be turned over to Dr. Thomas Mossman. The hygiene and sanitation program, including inoculation and other preventive measures, is in the hands of **Dr. M. F. Haralson** of the Board of Health.

**Dr. Harry Arnold, Jr.** leaves by Clipper in December to attend the meeting of the American Academy of Dermatology and Syphilology in New York. He will take the American Board examination and return on December 22, also by Clipper.

**Dr. H. M. Johnson** is instructor at the University of Hawaii to the nurses taking the Public Health Nursing course. His lectures deal with the methods, diagnosis and treatment of syphilis and other venereal diseases.

**Blood Plasma Bank:** Letter from the Public Health Committee of the Chamber was read, requesting expression from the Medical Society if in its opinion "the blood plasma bank might reasonably be expected to be an important factor in the conservation of the health of the port" and if so would "200 flasks form an adequate basic supply."

It was the consensus that the blood plasma bank is an important factor as stated above and that 200 flasks should be regarded as only a beginning. The Secretary was instructed to so advise the Public Health Department.

\* Ten years ago.



### Hawaii Cancer Society

Authentic information about cancer is being brought to the public weekly in "Hawaii Health Review," a 15-minute program presented over KHON every Monday from 7:30 to 7:45 p.m.

The program is sponsored by the Hawaiian Surgical Supply Co., a subsidiary of the Hawaiian Gas Products, Ltd., and is produced by the Hawaii Cancer Society in cooperation with the Territorial Medical Association and the Territorial Department of Health. It is conducted by Alan G. Slipper, manager of the surgical supply company.

It was started about the first of June with a program in which several representatives of the cooperating agencies took part. Since then it has featured a series of informal interviews with doctors and others who specialize in the cancer field.

Areas covered thus far in the programs have included the seven danger signals as set forth by the American Cancer Society, as well as symptoms and other information concerning cancer of the skin, digestive tract, lung, female genital tract, breast, nose and throat.

The public is invited to send in questions to be answered on the program.

*Urology Award*—The American Urological Association offers an annual award of \$1000.00 (first prize of \$500.00, second prize \$300.00 and third prize \$200.00)

for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Chalfonte-Haddon Hall, Atlantic City, New Jersey, June 23-26, 1952.

For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before February 15, 1952.

### Award for Outstanding Research in the Field of Infertility

The American Society for the Study of Sterility announces the opening of the 1952 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of one thousand dollars, and the essay will appear on the program of the 1952 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1952. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Massachusetts.

*Keleket*

*The oldest name in X-ray*



**X-Ray Apparatus  
Accessories — Supplies**

*The* **LIEBEL**  **FLARSHEIM Co.**

**SHORT-WAVE DIATHERMY**

*Distributed by*

**Wadsworth's**  
PHOTO MATERIALS  
SINCE 1925

1158 Fort St.  
Honolulu

Phone 5-6040  
or 5-6045

**WRITE FOR FREE DETAILED LITERATURE**

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

---

## BULLETIN COMMITTEE

LAURA DRAPER, *Editor*, Board of Health, Honolulu

LEAH BIGALOW, *Nursing Information Committee*, St. Francis Hospital, Honolulu

LEONA ADAM, *Executive Secretary*, Honolulu

ISABEL MEDEIROS, *Territorial Association Secretary*, Honolulu

### *Secretaries*

MARGARET BARNETT, Hawaii

VIRGINIA RAUTENBERG, Honolulu

PAULINE JOHNSON, Kauai

JOANN GROBERG, Maui

### *Publicity Chairmen*

EDNA BALDWIN, Hawaii

TSUGU KADOTA, Kauai

ELIZABETH MCCALL, Maui

---

## PRESENT DAY CUSTOMS RELATING TO CHILDBIRTH AND INFANT CARE AMONG HAWAIIANS

ALISON MacBRIDE\*

Many of the customs of old Hawaii concerning childbirth and infant care stand up well in the light of modern knowledge of what constitutes good maternity care. However, discussions with living Hawaiians indicate that much has been forgotten and that only a few of the protective tabus and practices of old Polynesia guide the mother and child of today. In this paper, an attempt is made to assess the extent to which certain customs prevail and influence Hawaiian families in their reaction to childbirth.

While many of the protective elements in the old culture have been forgotten, Hawaiian families have not generally embraced modern hospital and medical care as acceptable substitutes. Hawaiian babies have a higher mortality rate during the first year of life than do infants of other racial origins in the Territory. The Hawaiian mother more often than not elects to have her delivery at home, assisted by friends and family rather than by physician or midwife.

There are about 200 so-called "informant" deliveries each year in the Territory and three quarters of them are deliveries of Hawaiian mothers. In 1949, only 166 Hawaiian infants were born, and since the largest proportion of informant deliveries are among Hawaiians, it is reasonably safe to assume that only a few Hawaiian mothers and

infants receive the benefits of modern science for one of life's most critical events.

Sociologists remind us that cultural transition is a slow and gradual process, more particularly with an independent and intelligent people like the Hawaiian. He continues to live in the environmental matrix of his heritage out of which custom evolved. Quite different is the case of people of other racial origins in Hawaii, who voluntarily transplanted themselves and because of that have been more ready to abandon their cultural ways and substitute elements of the new culture they came to live within.

In order to ascertain to what extent the old practices relating to childbirth and the care of the infant persist, opinions were sought from ten Hawaiians of varying background, most of whom were mothers. The size of the sample does not justify generalizations, and the following findings are presented only as cursory impressions gained by the interviewer about some of the forces which are influencing our modern Hawaiians.

The ancient Hawaiian theory of nature regarded all phenomena as psychophysical. Deep seated illness and abnormalities were ascribed to psychic conditions and causes. These malevolent influences often came from outside the sufferer and might result from concentrated spite, hate or jealousy in the heart of another, or the condition might be the result of possession by a ghostly demon spirit who had escaped from its keeper. Pregnancy had status, and was considered to be vulnerable to such psychic genera, particularly jealousy. Consequently, the fact of pregnancy was a carefully guarded secret.

\* Assistant Chief, Bureau of Public Health Nursing, Department of Health.



There are several indications that these theories still prevail, with all the implications possible for mother and child. Pregnancy is not spoken of freely and is kept within the bosom of the family for fear of another's jealousy. A woman has to be careful not to eat a food which in the form of a bird, fish or animal represents her guardian spirit or angel, lest protection be withdrawn. Ti leaves worn next to the skin are believed to ward off evil. It is common practice of Hawaiian friends and relatives to gather for prayer to release a woman who has complications at childbirth. Screaming is regarded as a sign of possession. Excessive labor pains, which may be due to an evil cause from without, will be transferred by these prayers to a proxy—another woman who is glad to help her laboring sister.

In keeping with this psychic theory, the vestigial remains of an ancient purification ceremony are sometimes practiced. This ritual drives out any lingering malevolent influence from the mother just before the infant is born. A *kahuna* person or elder presides and receives the woman's confessional, then a suckling pig or garden-variety chicken is sacrificed.

Another related custom is found in the observance of the ancient tabu on sewing or knitting or lei wearing during pregnancy lest the infant be strangled by the umbilical cord.

In old Hawaii, the mother's diet was strictly regulated from the fourth month on: no hot spicy foods or too many salty foods were allowed. Greens of various kinds (*popolo*, *luau*, etc.) and mild medicinal herbs were advocated to build up the body of the child. These greens were high in vitamins, iron and calcium and are recognized nutritional requirements for health today. Some Hawaiians add seaweed to the diet in extra amounts in the last trimester and the tabu on spicy foods is observed which is a sensible way to avoid digestive discomfort. The Hawaiian diet today leaves much to be desired from the standpoint of nutrition during pregnancy, however. Fruits, vegetables and milk intake is low, and since rice is supplanting poi to an undesirable extent, the diet is often deficient in calcium as well as vitamins A and C. In respect to her diet, the modern Hawaiian mother lacks the protection which the ancient dietary tabus provided to the pregnancy.

On a lighter side some of the most delightful imagery is contained in the ancient folklore surrounding food cravings. It was believed that the disposition, health and behavior of the child were determined in utero and could be predicted by these cravings: if the mother craved a *pili* (bi-

valve which clings to a rock) the child will have a very affectionate nature and only death itself will part him from loved ones; if she craved a *manini* (fish which hides in recesses of coral reef) he will be shy; if *luau* (taro tops) he will answer questions only by nodding his head like the swaying of the taro leaf. Sex could be determined by asking the mother for her hand which if extended palm up meant the child would be a girl, and if palm down the child would be a boy.

Modern science still has no light to throw on the reasons for capriciousness in food habits during pregnancy and the modern Hawaiian does not subscribe to the theory that these cravings predict personality characteristics. Only one story was elicited in support of this ancient folklore: only after one mother observed her wriggling son did she remember she had craved a sea urchin early in pregnancy! However, the pregnant woman is still apt to have an oldtimer ask her for her hand and thereupon learn the sex of her child.

The ancient concept that parental behavior during pregnancy will affect the nature of the child finds corroboration in modern epidemiologic concepts in the field of mental hygiene. Ancient and modern Hawaiians believe that if parents are lazy, their offspring will be lazy and poor providers, so the Hawaiian mother is apt to be busier than usual during pregnancy. The family behavior pattern is recognized today as generic to personality development.

The old *kahuna* used postural exercises and *lomi-lomi* to make delivery easier. The expectant mother still employs the massage skills of her mother or a relative expert in *lomi-lomi* in the last trimester to reach the same goal—strong muscles to facilitate delivery. The grandmother-masseuse is continuously observant of the infant's position and manipulates the abdomen manually to assure a vertex presentation. It is interesting to note the recent emphasis in obstetrical practice to include exercises and relaxation regimes as a part of prenatal care.

In some cases even today relatives gather for the birth of the child. The mother is encouraged to walk to and fro and when the pains become more intense, she takes a kneeling position with her knees apart. A relative places his knees on her back and when the child is born grasps her around the waist and exerts pressure on the fundus; another relative supports her in front, knee to knee and hand to hand. This squatting position is still preferred by many women. It is the natural position in many cultures and the common prac-

ice of insisting that a woman deliver in bed is contrary to primitive, instinctual dictates.\*

After the birth, the mother was given a warm broth and herbs to help her fill the empty feeling (*bakahaka*) and to expel excessive blood. Different kahunas had their own preferences as to herbs. Various herbs crushed in water are given today; the one most frequently mentioned was the ashes of guava stumps. When tearing has occurred, a pad saturated with *olena* (ginger), *alae* (red dirt), salt and water seems to have remarkable healing effects. The Hawaiian believes it is bad to wet the umbilical stump, and keeps it dry, using *pia* (starch) to correct bleeding.

The old folklore prescribed caution in the disposition of after-birth and navel cord (*piko*). These are considered to be extensions of the child who will be affected if they fall into the wrong hands: if a rat eats *piko* the child will be a chronic thief. The after-birth was washed well to avoid the child having sore eyes; then it was buried deep, and a tree planted over it which could not be cut down as long as the child lived. Many stories were told in which the after-birth or miscarriage products were thrown into the ocean and became a family guardian spirit in animal form. Similarly the after-birth is protected today by deep burial and the place often kept a secret.

In Haleole's romance of *Laiei Kawai*, the old grandfather who saves the life of the twin sister, wears her navel cord around his neck to keep it from harm. On each island there were designated places of safety for the disposal of *piko*, for example, at Honomalino landing in South Kona there is a rock of legendary interest which appears above the surface at low tide; in the old days anxious parents, seeking the welfare of their offspring were wont to travel some distance to secrete *piko* in a hole in this rock which was then sealed by a smaller stone.

Preservation of *piko* is still regarded as an important charge upon parents or guardian of the child until it can be disposed of safely. Many a Hawaiian home has these treasures stored in a bottle or metal powder box.

It was the old custom that the first son would be reared by paternal grandparents and the first daughter reared by maternal grandparents. If these parents were dead, the relative next in seniority line assumed responsibility for these children. The presumptive guardian always was present and assisted with the birth. There continues to be social pressure exerted upon parents to give up first born children to grandparents; however, the mothers who were interviewed had been successful in

repudiating the claims of grandparents to their offspring.

The Hawaiian baby's first solid food was mashed sweet potato. At six months, poi was given and a little later, the soft parts of the limpet, vegetables and meat broths were added. By the end of the first year mixed herbs were given, mashed *kukui* nuts, crab juice and vegetables. When an infant required medicinal herbs, the mother chewed these and mouth-to-mouth feeding was administered,

The modern one-year-old is customarily given a slightly different variety of foods, but the dietary principles are similar; in addition to his mother's milk (or that of a wet nurse) foods rich in minerals, vitamins and protein are added, poi is still the most important supplement to milk.

Hawaiian mothers and grandmothers carry along the old belief in the value of massaging and stroking the infant's head and extremities, particularly the fingers, to develop a well formed body. Swathing the infant in tight binding cloth to keep back and legs straight was not resorted to as in many European cultures. It is not an uncommon sight to observe mothers stroking their children purposefully and in a manner not observed among other racial groups in the islands.

Hawaiians did not express any fear of hospitals or medical care, rather an indifference toward them. The modern Hawaiian frequently combines the old therapeutic practice with the modern when she is under the care of a medical doctor.

Another potent force working against modern hospital and medical care in the Hawaiian community is the tales of individuals' unfortunate experiences with professional personnel. These stories are told and retold whenever the problem of hospitalization arises. That this force is a particularly potent one cannot be doubted when one remembers that the Hawaiians had no written language and history and tradition was and is handed down by the spoken word generation to generation through meles and storytelling. This fact of community life provides a chain reaction effect for each hospital experience of a Hawaiian whose pride and sensibilities have been trammelled wittingly or unwittingly by an insensitive nurse, doctor or other hospital worker.

Bibliography

Bryan, E. H.—*Ancient Hawaiian Life*, Honolulu 1938.  
Beckwith, M. and Green, L.—*Hawaiian Customs and Beliefs Relating to Birth and Infancy*. Reprint ex. *American Anthropologist*, Vol. 26, No. 2, 1924.  
Wise, J. and Larsen, N.—*Ancient Hawaiian Civilization*, p. 253, Hono. 1933-35, Bishop Museum Memoirs, Vol. 6.  
Fornander Collection of Hawaiian Antiquities and Folklore, 1916.  
Larsen, N.—*Medical Arts in Ancient Hawaii*, 53rd Annual Report of the Hawaiian Historical Society, 1944.  
British Medical Journal, January 31, 1950.  
Handy, E., Pukui, M., Livermore, K.—*Outline of Hawaiian Therapeutics*, Bishop Museum Bulletin 126.

\* Vaughn, K., *British Medical Journal*, January 1950.



## Refresher Course, Summer 1951\*

### NEW DRUGS

M. E. BERK, M.D.

Of the new drugs which have become available in the postwar years many have been very successful and some have not been of any real value.

*Anti-ulcer drugs:* The one which has stimulated the greatest furor is Banthine; this drug works by inhibiting the formation of gastric juices which include free hydrochloride. Other additions to the anti-ulcer regimen are resins; these work by a chemical combination with the acid instead of a neutralizing process such as most people are familiar with.

*Peripheral vascular disease:* Many new drugs have come out in this field. Basically, they all tend to work by sympathetic paralysis, that is, causing a marked dilatation of the blood vessels supplying the peripheral muscles. Such drugs are: Myanesin, which is better known in this country under the trade-names of Tolserol and Ornixon. Other drugs are: Priscoline, Dibennamine, and Tetraethylammonium.

*Insulins:* In addition to plain insulin, crystalline insulin, and protamine zinc insulin, there have been two additions. One was added before the war and is known as globin insulin. It is a long-acting insulin which usually lasts about 24 hours. Its peak of activity is at 8 hours. The newest and most popular long-acting insulin is NPH50. It is an almost neutral solution of plain insulin with protamine zinc insulin and acts very much the same as a 2 to 1 mixture of plain and protamine zinc insulin. Its peak of activity is between 12 and 14 hours.

*Cardiac drugs:* The two most important additions in this field, besides the various glycosides of digitalis, are: Procaine amide which goes under the name of Pronestyl commercially. It is particularly useful in ventricular arrhythmias, although recent work indicates it may be of value early in the treatment of auricular arrhythmias. Another addition has been the cation resins; these are given to cardiacs in failure and to any other patient whose body tissues are loaded with sodium ion. The cation resins do not remove the sodium, which is retained in the tissues, but they do tend to prevent absorption of the daily sodium intake, providing too large an intake is not permitted. There are also several new mercurial diuretics on the market. The greatest advantage to these is that the more recent ones can be given intramuscularly or subcutaneously without any undesirable effect.

*Antibiotics:* The most important ones are: Penicillin, streptomycin, aureomycin, chloramphenicol, neomycin, and bacitracin. These cover a wide spread of bacterial organisms and in the instance of aureomycin and chloramphenicol the rickettsial diseases are also included. Streptomycin and dihydrostreptomycin are useful in the Gram negative organisms, such as E-coli, and streptomycin itself is now found in common usage for the treatment of active tuberculosis. Bacitracin, which is one of the most potent of the antibiotics, is still too toxic to be given intramuscularly or intravenously, but it can be used in ointment form for tropical application.

### PARENTERAL FLUID ADMINISTRATION

T. H. MAEDA, M.D.

One of the greatest advances in modern medicine has been the development of the technic of maintaining fluid and electrolyte balance in patients unable to take oral foods and fluids. It must be remembered that the best method of giving simple fluids is by mouth unless definite indications for parenteral therapy exist.

#### A. INDICATIONS:

1. Maintenance of fluid and electrolyte balance in patients unable to take fluids by mouth.
2. In considerations where the parenteral route is preferable to the oral route, as
  - a. Prevention of postoperative distention, or
  - b. In treatment of acute diarrheas where parenteral routes rest the gastrointestinal tract in addition to supplying needed fluids and electrolytes.
3. Nutrition—Considerable quantities of aminoacids and glucose can be given parenterally and thus supply a large part of the nitrogen and caloric requirement.
4. Restoration of blood and plasma volume with blood or blood substitutes.
5. Administration of drugs not absorbed or tolerated by mouth, i.e. penicillin.
6. Intravenous anesthesia, i.e. pentothal sodium.

#### B. IMPORTANT CONSIDERATIONS in fluid and electrolyte balance are:

1. The average adult having an operation or illness requiring hospitalization needs an intake of at least 2,500 to 3,000 cc. of fluid per day to keep his urinary output above 1,000 cc.
2. All forms of abnormal losses via sweating, diarrhea, drainage, etc., must be estimated or measured. Replacement of these losses with plain saline solution was formerly recommended, but recently 0.5% saline made isotonic with glucose has been suggested. This change has been recommended, especially postoperatively, because of salt intolerance.
3. Unless abnormal losses are present, an intake of 9-10 gms. of salt in both diet and fluid is ample for the average person. Additional amounts may cause salt retention, especially if renal damage is present.

The Medical Group

\* Sponsored by Curriculum Committee of Hawaii League of Nursing Education.

4. Blood and plasma losses must be estimated and, if excessive, be replaced by blood or plasma substitutes—not simple fluids. The latter aid if no blood or blood substitutes are available.
5. Persons in congestive or so-called right-sided heart failure should be given parenteral fluids only if absolutely necessary and then slowly without salt in the fluids or diet. Even small amounts of salt in their diet may accentuate edema.
6. Patients with impending pulmonary edema or so-called left-sided heart failure (hypertensives, coronary artery disease) should be given parenteral fluids very slowly and plasma substitutes very sparingly since it seems to be the increase in blood volume that precipitates pulmonary edema. It is better to give too little salt to these patients than too much.
7. Renal patients present problems in fluid and electrolyte balance too complicated to consider here. Therapy is directed at trying to return abnormal chemical findings toward normal without introducing too much sodium ion.

### C. METHODS OF ADMINISTRATION

1. Hypodermoclysis—This method is not used often now.

#### (a) Indications:

- (1) Where fluid need is not acute.
- (2) In patients with poor circulation to prevent overloading.
- (3) Where there is no local infection of the thighs.
- (4) After prolonged intravenous therapy when the available veins are thrombosed.

#### (b) Contraindications:

- (1) Usually unsatisfactory in patients whose serum proteins are so low or in whom the heart is so damaged that the fluid will not be absorbed.
- (2) Only relatively isotonic, non-irritating solutions, such as physiologic saline or a 3 per cent solution of glucose in saline, can be given. Distilled water should never be given under the skin.

#### (c) Technique:

Hypodermoclysis may be given into the thighs, the abdomen, or the axillae. The preference is for the thighs. The patient lies flat in bed with the knees elevated on a pillow. The anterior or lateral aspects of the thighs are prepared with alcohol and are draped with sterile towels. The inner aspect of the thigh is more acutely sensitive to pain than the anterior or the outer aspect. If the air is not removed from the tubing, it may block the flow of fluid, or if it enters the tissues, it may cause a harmless but often perplexing subcutaneous emphysema. With the left hand the skin of the thigh is pinched between the thumb and fingers and is gently elevated from its normal position so as to separate it from the fascia and to insure that the needle will not be introduced deep into the fascia. The needle is held parallel to the thigh and is introduced into the subcutaneous tissue. Gauze is placed beneath the hilt of the needle, wrapped over it, and held in place with adhesive strips.

#### (d) Precautions:

- (1) The skin should not balloon out—needles are too superficial if it does.
- (2) The needle should not be left in place more than 4 hrs. If properly inserted 2,000 or more cc. of fluid can often be administered in this time.
- (3) The infusion can be given by an experienced nurse.

#### (e) Solutions which may be used are:

- (1) Isotonic solutions, such as 5% glucose in water, 2½% glucose in 0.45% sodium chloride, and 1/6 molar sodium lactate.
- (2) Wydase (Lyophilized Hyaluronidase by Wyeth) may be used for speedy absorption of fluids in hypodermoclysis. It prevents pain from stretching of tissue. It is nontoxic and apparently nonallergenic.
- (3) For only pain relief, 30 cc. of 1% Novocain in 1,000 cc. of solution may be used.

2. INTRAVENOUS INFUSION: This is the most commonly used method.

#### (a) Advantages:

- (1) The speed of infusion may be easily changed.
- (2) It is the best means of giving blood and blood substitutes.
- (3) Some drugs can be given only in this way.
- (4) If the needle is carefully inserted in a forearm vein, the patient is quite comfortable.

#### (b) Disadvantages:

- (1) Possible circulatory embarrassment.
- (2) Thrombophlebitis.
- (3) Technical disadvantages of venipuncture and of keeping infusion going.

#### (c) Indications:

- (1) Rapid absorption is desired.
- (2) When the fluid cannot be taken by mouth and is too irritating to the tissue to be given by hypodermoclysis.
- (3) When the amount of parenteral fluid to be given is so great that it could not be efficiently absorbed by hypodermoclysis. The intravenous administration of fluid entails the danger of inducing a reaction, but fluids given intravenously certainly cause less discomfort than those given under the skin.

- (d) Contra-indications: Fluids should not be given intravenously or should be given slowly and in small amounts:

- (1) In the presence of cardiac decompensation, or
- (2) In patients with myocardial damage.

#### (e) Equipment for Venoclysis:

- (1) Murphy drip and stopcock to regulate rate of flow.
- (2) 20 gauge needle.
- (3) Tourniquet.
- (4) Antiseptics and sterile gauze for preparation of skin.
- (5) Adhesive tape to strap needle in place.
- (6) Standard to hold flask.

#### (f) Technique:

- (1) Selection of vein—The median cubital or the Basilic veins are usually selected for



venipuncture. Slapping the skin and massaging the arm will sometimes make the veins stand out more prominently. If the veins of the arms are not satisfactory, as is often the case in obese patients, the veins of the legs, or even the external jugular vein may be used in infants.

The superficial cutaneous veins, which are visible on the hands and on the feet, are thin-walled, are not supported by areolar tissue, and tend to roll off the point of the needle. A deep vein, if it is palpable, is easier to hit than a clearly visible superficial cutaneous vein. This is particularly true with respect to veins of the feet. The thin-walled, movable, cutaneous veins are often more difficult to use than the less conspicuous anterior malleolar vein. The location of the anterior malleolar vein is so constant that a needle often can be inserted into it even when the vein is neither visible nor palpable. In a patient whose arms and legs have been burned or when no other vein can be found, it is usually possible to insert a needle into the femoral vein just below Poupart's ligament. The pulsation of the femoral artery is palpated, and the needle is then introduced medially, vertically, or at a slightly oblique angle. In an emergency, fluids or medication can be given by this route, but the possibility of producing a thrombosis of this important vein must always be considered.

(2) *Eliminating air from tubing*—Before fluids are given intravenously, all air should be removed from the tubing. Bubbles of air are usually visible through the thin plastic tube, but both the tubing and the needle should be raised above the level of the flask so that any air bubbles may be forced back into the Murphy drip; the remaining air bubbles to escape by way of the needle ahead of the solution. A small amount of air, even if it is given directly into a vein, will do no harm, but a tube full of air, if given rapidly, could conceivably result in air embolism.

(3) *Application of tourniquet*—A tourniquet should be applied in such a way as to distend the veins. If it is applied too tightly, the arterial blood supply will be shut off, and the veins will not be distended. As soon as the needle is in the vein, the tourniquet should be removed lest the increased venous pressure result in extravasation.

(4) *Introduction of needle*—The point of the needle is inserted through the skin with the bevel upward and parallel and lateral to the vein so that the impetus of the needle, after it has traversed the skin, does not carry it on through the walls of the vein. The needle is then introduced into the vein at an oblique angle. Blood escapes from the vein into the needle and should be seen in the glass connector at the end of the tubing. The tourniquet is removed, the stopcock is released, and the fluid is allowed to flow.

Either an 18 or 20 gauge needle is used for intravenous therapy. It should be sharp, and the bevel should be short. A long bevel is

apt to perforate the opposite side of the vessel and cause an extravasation of blood.

(5) *Immobilizing the needle*—A small piece of cotton or gauze is placed beneath the glass adapter to hold the needle in the vein at about a 30 degree angle. The needle is fixed in this position by strips of adhesive tape  $\frac{1}{2}$  inch wide, placed across the end of the needle and the glass adapter.

(6) *Rate of flow*—Under ordinary circumstances, fluid should not be given at a rate to exceed 1 liter in two hours, which is approximately 120 drops per minute.

(g) *Common errors and complications of intravenous therapy.*

(1) *Failure of fluids to flow*—If the needle is apparently in the vein and the solution still fails to flow, it is possible that:

- (a) The tourniquet has not been removed.
- (b) The vein is thrombosed.
- (c) The point of the needle is resting too firmly against the wall of the vein.
- (d) The needle is plugged.

(2) *Extravasation of fluid*—The most common complication associated with the intravenous administration of fluid is extravasation of the fluid into the tissues. This complication should cause no concern when isotonic saline or dilute solutions of glucose are used, but when hypertonic saline or glucose or acids or alkaline solutions extravasate in the tissues, a slough may follow. As soon as the complication is discovered, the needle should be withdrawn, and the affected part massaged to disperse the fluid as rapidly as possible. Thrombosis of the veins becomes troublesome after repeated venoclysis. The greatest intimal reaction occurs at the point at which the needle is inserted. If repeated venipuncture is contemplated, the site of the venipuncture should be varied in order to reduce the incidence of thrombosis. The intravenous solution should be kept running slowly all the time lest the wall of the vein collapse, agglutinate, and block the flow of fluid.

(3) *Chills and fever*—The cause of chills and fever after intravenous administration of fluids is not clearly understood. Although improper sterilization of solutions and cleansing of apparatus may be responsible for some reactions, other factors, including the too rapid administration of the fluids, appear to play a part. The reactions may be alarming but in the absence of other complications are rarely fatal. If serious hyperthermia occurs, the patient should be packed in ice until the temperature is under control. Most reactions are caused by tubing rather than by the solution.

(h) *Cutdown technic*: The indications are (1) any time it is desirable to give intravenous fluids rapidly and (2) the available arm and leg veins are not able to be located, are collapsed due to shock, or are thrombosed from previous technic. This procedure will not be used by a nurse, therefore further explanation will not be made.

## WHAT IS YOUR "FUNCTIONS" DOLLAR BUYING?

You will be interested to know that the dollar you contributed this year to the ANA for studies of nursing functions has already gone into action. The first five grants have been made under the five-year one million dollar research program.

The first grant is for \$10,000 to the California State Nurses' Association toward a study to determine current nursing practices of professional nurses, practical nurses and auxiliary nursing workers. The findings should answer some of our questions as to proper distribution of functions among all types of nursing personnel.

The Boston Psychopathic Hospital has received a grant of \$12,860 for the first year of a two-year study to investigate the effect on mentally ill patients of changes in patient population, normal daily events, changes in number and in type of nursing personnel, and changes in social functioning of personnel.

To the Charles T. Miller Hospital in St. Paul, Minnesota, goes a grant of \$1,756 for a one-month activity study of all nursing personnel in the hospital.

Purposes of the other two grants are less specifically designated but are to the New York Conference Committee for the Improvement of Patient Care, \$5,000, and to the Rhode Island State Nurses' Association, \$1,756.

L.A.D.

## FIRE AT PRACTICAL NURSE TRAINING QUARTERS

The building of the Practical Nurse Training School at 916 Pensacola Street was almost completely destroyed by fire of undetermined origin on the night of September 10. The equipment of the home management room, including chairs upholstered by former students, as well as gifts from the alumnae association and some gifts from graduating classes, was entirely lost.

Many books, much bed linen, all mattresses, and pillows were burned. However, soap and water with plenty of elbow grease has restored to use many articles so charred and sooty that they at first appeared beyond salvage.

A new location on the McKinley campus and near the site of the old building is being renovated by the City and County. In the meantime classes are being conducted at the Convalescent Nursing Home, Leahi Hospital classroom, and in the one remaining room of the bungalow.

The address and telephone number (5-2349) of the school remain the same.

## Kauai Notes

The annual May and August Rummage and Plant sales of the Kauai Nurses' Association were highly successful. The proceeds are awarded annually to two Nursing scholarship students. Two of our scholarship students are enrolled in the St. Francis Hospital School of Nursing. They are Miss Yupemia Padilla, second year student, and Miss Edith Takashiro, pre-clinical student. Another scholarship student, Miss Hiroko Kakoda, is with The Queen's Hospital School of Nursing.

Miss Ruth Imai, public health nurse, Lihue district, was recently married to Dr. E. Masunaga of Hanapepe.

Miss Alice Tanaka, public health nurse, Waimea district, left August 25 for postgraduate work at the University of Oklahoma.

*Wilcox Hospital:* Recent newcomers to the nursing staff include Miss Dale Ibata, graduate St. Francis Hospital School of Nursing, and Misses Alice Iwamoto, Fukiko Izawa, Mildred Mukai and Harumi Kudaishi, all of whom are graduates of The Queen's Hospital School of Nursing.

## FACULTY CHANGES AT THE QUEEN'S HOSPITAL SCHOOL OF NURSING

Mrs. Rosie K. Chang, R.N., M.A., Educational Director. (Former Assistant Director of Nursing.)

Miss Mildred Asato, R.N., B.S., Clinical Coordinator. (Former Clinical Instructor.)

Miss Kathryn Fox, R.N., B.S., Nursing Arts Instructor. (Former Clinical Instructor.)

Mrs. Violet Matson Larson, R.N., B.S., Clinical Instructor. (Bethseda Hospital School of Nursing, St. Paul, Minnesota; University of Minnesota, Minneapolis, Minnesota.)

Miss Ruth Shinn, R.N., B.S., Clinical Instructor. (The Queen's Hospital School of Nursing, Honolulu, T. H.; University of Rochester, Rochester, New York.)

Miss Mary Tolles, R.N., B.S., Clinical Instructor. (St. Joseph Mercy College of Nursing, Sioux City, Iowa; Briarcliff College, Sioux City, Iowa.)

## St. Francis Hospital

Miss Karen Tanaka and Miss Vivian Zane both graduates of the School of Nursing, left early in September to matriculate at the University of Dayton, Dayton, Ohio. Both are studying for Bachelor of Science degrees in Nursing Education.

Miss Betty Ito, a 1949 graduate of the School of Nursing, received the nurse scholarship award from the Japanese Junior Chamber of Commerce this year. She is matriculating at Columbia University in order to complete work for a bachelor's degree.

Sister Laurine, well known to the nurses in the Territory, returned to Hawaii in August after having completed work for a B.S. in nursing education degree at the Catholic University of America. She replaced Miss Karen Tanaka as instructor in nursing arts.

Sister Maureen arrived in Honolulu in September to become an assistant to Sister Jolenta, Administrator. Sister Maureen is a graduate of St. Joseph's Hospital School of Nursing in Syracuse, New York. She received her B.S. in Nursing Education degree from the Catholic University of America, and has begun work on her master's degree.

Twelve of the twenty-six students who were graduated from the School of Nursing in August, accepted



positions on the nursing staff of their alma mater. They are the Misses Esther Aranio, Emiliana Daniel, Rosario Dela Cruz, Dorothy Karakawa, Hazel Morada, Naomi Nakatsukasa, Laraine Tamashiro, Ethel Kawakami, Peggy Watanabe, May Lau, Mrs. Conchita Andres Leavy and Mrs. Hope Chow Fong. Other new general staff nurses are Miss Ruth Rogers, graduate of Royal Jubilee Hospital School of Nursing, Victoria, Canada; Miss Gene Garas, graduate of The Queen's Hospital School of Nursing; Miss Shirley Benoit, graduate of St. Boniface Hospital School of Nursing, Manitoba, Canada, and Miss Delores Ritter, graduate of St. Alexis Hospital School of Nursing, Bismarck, North Dakota.

**Whenever you change your address, please be sure to notify**

**Mrs. Grace Page, Office Secretary  
Nurses' Association, Territory of Hawaii  
Mabel Smyth Building  
510 South Beretania Street  
Honolulu, Hawaii.  
Phone: 6-8630**

**Magazines sent to your former address cannot be forwarded by the Postoffice.**

**Your subscription will be temporarily suspended if your BULLETIN is returned to us because of a wrong address, and you will be notified by post card.**

## POSITIONS AVAILABLE

### *Honolulu and Oahu:*

Supervisor, \$237.50 plus \$25 bonus.  
Surgery Nurse, \$245.  
Staff Nurse, \$265.  
Obstetrics Supervisors, \$275 & \$300.  
Asst. Director of Nursing, \$300.  
Surgery Supervisor, \$275.  
Educational Director, \$300.  
Director of Nursing School and Nursing, Open.  
Science Instructor, \$275.  
Physical and Biological Science Instructor, \$290.  
Registered Anesthetist, \$325.  
Supervisor, Medical-Surgical Dept., \$250.

### *Maui:*

Staff Nurse, \$244.17.

### *Hawaii:*

Staff Nurses, \$262.50.

### *Kanai:*

Night Supervisor, \$265.

### *Molokai:*

Staff Nurse, \$235.

For further information contact the Department of Counseling and Placement Service of the Nurses' Association, Territory of Hawaii, Mabel Smyth Building.

## MUSIC, CHERUBS AND BLUEBIRDS SISTER LAURINE\*

It began so long ago, these hobbies of mine; therefore I'm wondering if you would be interested. Being a poor Franciscan limits my collection somewhat—expenses you know.

However, records head the list. All sorts of them! To this day, I have seventeen albums featuring the great works of Tschaikowsky (Swan Lake Suite), Rogers and Hammerstein (South Pacific and Oklahoma), Friml (Red Mill), and a host of others. Of course, there are discs of Crosby's love for Hawaii, Alfred Newman's "Clair de Lune," and Vaughn Monroe's "Riders in the Sky." The taste for selections normally varies with the mood.

Then comes statuettes—of cherubs, that is. Fat ones, sleepy ones, cheery ones, angels of all shapes and forms adorn the office book rack and window sill. What price poverty! These gifts of china and clay range from \$2.50 to \$10.00. Yet friends are so kind.

Lastly, the hobby I cherish above all others is the collection of bluebirds. (Not live ones, to be sure.) Having once been called a "bluebird," I've always wanted to live up to such a nice name. For the bluebird is symbolic of happiness.

\* St. Francis Hospital School of Nursing instructor in Nursing Arts.

*In very special cases  
A very superior Brandy*



*Specify*

84 Proof

★ ★ ★  
**HENNESSY**  
THE WORLD'S PREFERRED  
COGNAC BRANDY

Schieffelin & Co., New York N. Y.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement of Actions and Uses and of Dosage for publication in connection with a description of Banthine Bromide for inclusion in New and Nonofficial Remedies)

## METHANTHELINE BROMIDE.—*Banthine*<sup>®</sup> Bromide (Searle)

$\beta$ -diethylmethylaninoethyl 9-xanthenecarboxylate bromide

**Actions and Uses.**—Methantheline bromide, a parasympatholytic agent, produces both the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastrointestinal and genitourinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and

therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degree may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

**Dosage.**—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial adult dose, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

G. D. SEARLE & CO.

Tablets Banthine Bromide: 50 mg.

Ampuls Banthine Bromide: 50 mg.



*Just what Mother Nature had in mind . . .*



## FRESH WHOLE MILK

Here is Nature's own proper balance of butterfat, protein, vitamins, highly assimilable calcium and other minerals . . . in a fine quality, Grade AA fresh milk that well exceeds territorial standards for butterfat content, milk solids and safety. No type of milk that is processed further can take the place of *fresh, whole* milk, in its natural form.

Note: Some patients prefer milk in Pure-Pak cartons; some in bottles. For the first time in Hawaii a choice of containers is now offered—exclusively by Dairymen's—both in stores and for home delivery.



## Dairymen's

RICH, PASTEURIZED MILK  
AND DAIRY PRODUCTS

Grade AA Fresh Milk  
Grade AA Homogenized Fresh Milk  
Golden Guernsey Milk  
Buttermilk  
Dari-Rich Chocolate Milk  
Non-Fat Milk

*Dairymen's Association, Ltd., a Division of Creameries of America, Inc.*

**It's here!**  
**The New Improved**  
**BIRTCHER**  
**Hyfrecator**

*For electro desiccation,  
 fulguration and coagulation.*

*Proven in use for 10 years  
 by over 50,000 doctors.*



**Now- Greater Power, Facility and Beauty**

NEW — the beautiful molded bakelite case designed by Walter Dorwin Teague, world-famous industrial designer.

- the double-sparkgap control for greater power, speed and facility in desiccation, fulguration and bi-active coagulation.
- the improved front panel for greater visibility and ease of operation.
- the larger calibrated dial control for easier adjustment and smoother graduation of current.

Here, too, are stamina, compactness and the remarkable versatility of 33 proven technics, as acclaimed by all who use the Hyfrecator.

Price remains the same . . . \$45.00

***Territorial Distributors***

**HOTEL IMPORT COMPANY**

DIVISION OF THE VON HAMM-YOUNG CO., LTD.

*Wholesale Druggists and Hospital Purveyors*

TELEPHONE 6-3562

COOKE AND KAWAIAHAO STREETS

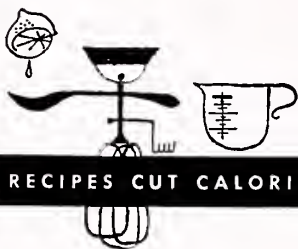
P. O. BOX 2630

Honolulu, Hawaii, U. S. A.



# Get this **BIG** new edition of "Calorie Saving Recipes"

*for diabetic and  
reducing patients*



**RECIPES CUT CALORIES 23 TO 89 PERCENT**



This 32-page booklet is crammed with appetizing, low-calorie recipes, all fully sweetened with SUCARYL,® the non-caloric sweetener that can be used just like sugar for a true, evenly blended, *cooked-in* sweetness.

Double the size of the first edition, the new booklet includes a section on *canning and freezing* with SUCARYL, a feature especially important to diabetic patients. And with the many new cooked and baked dishes that have been added, a wide variety of low-calorie menus is readily available.

**These recipes save from 23 to 89 percent in calories—an average saving of 43 percent—simply by using SUCARYL in place of sugar.**

To obtain a supply of these handy-to-use recipe booklets, just fill in and mail the convenient coupon below. Quick-dissolving SUCARYL Sodium tablets are available at pharmacies in bottles of 100 and 1000; SUCARYL Sweetening Solution, in either sodium or calcium form, is available in 4-fluidounce bottles. Recipes use either tablets or liquids.

**Abbott**



**SEND NOW  
FOR YOUR  
FREE SUPPLY**

ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS

**Without charge or obligation, please send me \_\_\_\_\_ copies of the new, enlarged SUCARYL recipe booklet.**

NAME \_\_\_\_\_  
(please print or write plainly)

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZONE \_\_\_\_\_ STATE \_\_\_\_\_

# Terramycin



## *dosage forms for optimal simplicity and flexibility*

For oral administration, Terramycin is supplied in Capsules of 3 potencies, as well as in a palatable Elixir and concentrated Oral Drops made possible by the unique solubility of this great antibiotic agent. Terramycin is the only broad-spectrum antibiotic available in these 3 forms which simplify oral therapy for patients at all age and weight levels.

For the treatment of severe fulminating infections, Terramycin Intravenous permits the attainment of immediate high serum concentrations. And for topical therapy of ocular infections, Terramycin is available as an Ophthalmic Ointment and an Ophthalmic Solution, both well tolerated and effective against a wide range of micro-organisms causing infection of the eye.

**supplied:** **Capsules:** 250 mg., bottles of 16 and 100; 100 mg., bottles of 25 and 100; 50 mg., bottles of 25 and 100; **Elixir:** 1.5 Gm. in 1 oz. diluent; **Oral Drops:** 2.0 Gm. in 10 cc. diluent with calibrated dropper; **Intravenous:** 10 cc. vial, 250 mg.; 20 cc. vial, 500 mg.; **Ophthalmic Ointment:** 5 mg. per Gm.,  $\frac{1}{8}$  oz. tube; **Ophthalmic Solution:** 25 mg., 5 cc. dropper-vial.

Antibiotic Division



CHAS. PFIZER & CO., INC., Brooklyn 6, N. Y.



# ISLAND SPORTSWEAR

## ...profits in prints

*Hawaii today is working to build industries to aid in expanding the economy. This series of advertisements calls attention to these forward steps and to their promise for Hawaii's future.*

One week each year Oahu takes time out to pay tribute to its traditions and celebrates its annual Aloha Week, and, as part of the celebration, stages what is probably the nation's biggest style show—*island-wide and all week long*.

The entire community models fashions for the occasion . . . Aloha muumuuus, holokus, holomuus. They're the islands unofficial but traditional "uniforms," and they fill as big a role in the year 'round economy as they do in the week of parades and pageants.

The casual, comfortable island clothes will this year bring in approximately \$5,000,000 on the wholesale market, more than half of it from exports. The rest are island dollars, which otherwise would have gone to the mainland. Two years ago the industry's value was only half that amount; its growth is almost entirely in the islands. Today sportswear is one of Hawaii's top exports and the industry has solid hopes of doubling itself again.

In 1920, when garment manufacturing was first recognized as a major industry, three firms employed less than 100 people to make overalls and work clothes. Today 32 firms employ more than 1,000 people and their products range from swimsuits to sarongs. Patterns are designed in Honolulu, then sent to the mainland where huge rotary presses print designs on fabric in up to half a dozen colors. The cloth is shipped to the islands for a production-line process of cutting, sewing, pressing, then finished garments go to market—all around the world.

Hawaii, putting into it's sportswear all the colors of a full rainbow, has found for itself a substantial pot of gold . . . and a growing industry for a growing community.



### FREE BOOKLET

A brief survey of Hawaii's growing sportswear industry has been published to show how island firms can build both local and export markets for their production. For a free copy, write The Hawaiian Electric Co., P. O. Box 2750, Honolulu.

*The development of new industries requires individual initiative and community cooperation. In keeping with this progressive spirit of growth, The Hawaiian Electric Co., Ltd., is constantly planning ahead, expanding its own facilities and equipment . . . building today for tomorrow's needs.*

**THE HAWAIIAN ELECTRIC CO., LTD.**



**BUILDING TODAY for Tomorrow's Needs**

*specific*  
therapy for  
urinary tract  
infections

**SULAMYD®**

(sulfacetamide Schering)

Rapidly cleared from the blood stream and excreted in  
high concentration in the urine in which it is highly soluble,  
SULAMYD combines broad antibacterial activity with  
a high degree of systemic safety and minimal renal hazard.  
Crystalluria is rare; damage due to renal blockage  
has never been reported.

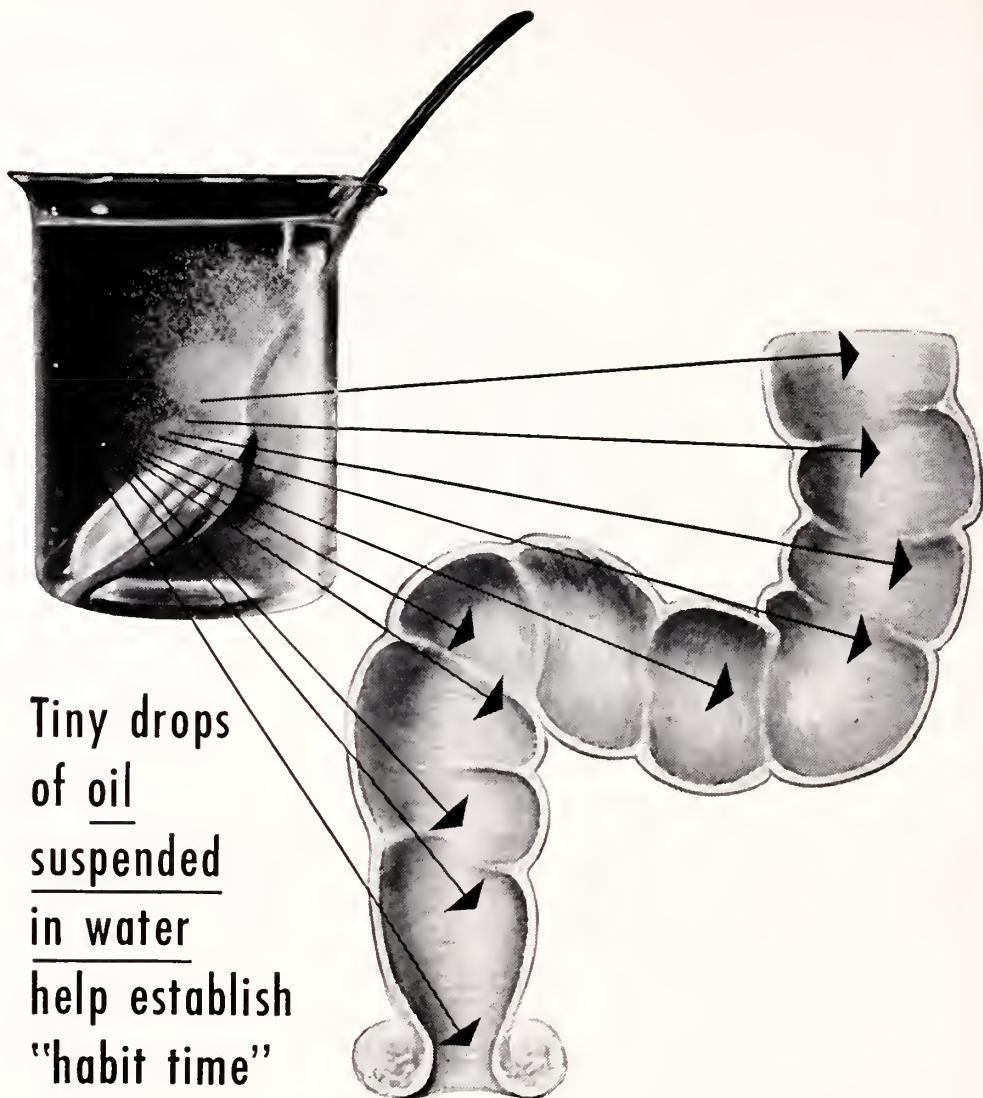
Available in 0.5 Gm. tablets.

*Schering* CORPORATION • BLOOMFIELD, NEW JERSEY

**SULAMYD**







Tiny drops  
of oil  
suspended  
in water  
help establish  
"habit time"

PETROGALAR provides a moderate intake of mineral oil in the form of a water-miscible suspension.

This oil-in-water combination permeates the fecal residue to produce:

- ▶ Gentle lubricant action, without "leakage"
- ▶ Soft, nonirritating, easily passed stools
- ▶ Comfortable bowel movement

PETROGALAR may be taken alone or in milk, water or fruit juices—with which it is readily miscible.

# PETROGALAR<sup>®</sup>

Aqueous Suspension of Mineral Oil, Wyeth



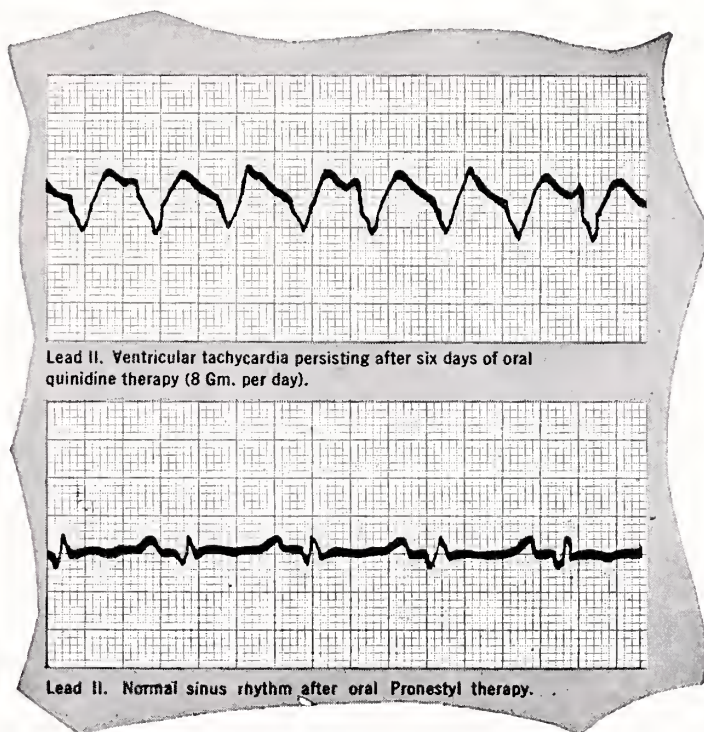
*Wyeth* Incorporated, Philadelphia 2, Pa.

a **new** drug . . .

*for the treatment of ventricular arrhythmias*

# PRONESTYL *Hydrochloride*

*Squibb Procaine Amide Hydrochloride*



Oral administration of Pronestyl is indicated in ventricular tachycardia and runs of ventricular extrasystoles. Intravenous administration is sometimes used in ventricular tachycardia and to correct ventricular arrhythmias during anesthesia. For detailed information on dosage and administration, write for literature or ask your Squibb Professional Service Representative.

PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.  
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

**SQUIBB** MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1853.



The background of the entire image is a repeating pattern of white lung silhouettes. Each silhouette is a stylized representation of a pair of lungs, facing forward, with a small vertical line indicating the trachea. They are arranged in a grid-like fashion, filling the entire frame.

reducin



# pulmonary embolism

"No case of post-operative death from pulmonary embolism" occurred in a study of heparinization<sup>1</sup> during a 9-year period in a hospital with 30,650 admissions. With early diagnosis, early ambulation and heparin treatment of thrombo-embolism, mortality was reduced from 18 per cent in a control series to 0.4 per cent.<sup>1</sup> Such advances in the control of thrombo-embolic phenomena have been made possible by the pioneering efforts of investigators in many centers of medical research.

Upjohn research has contributed new and advanced preparations. A single, deep, subcutaneous injection of Depo\*-Heparin (30,000 to 40,000 U.S.P. units—approximately 300 to 400 mg.) "will give a lengthened coagulation time of 2 to 4 times normal for about 24 hours."<sup>2</sup>

*For practicable and prolonged thrombo-embolic control:*

## Rx Depo-Heparin

Each cc. contains: Heparin Sodium ..... 20,000 U.S.P. units  
(Approximately 200 mg.)  
Gelatin ..... 180 mg.  
Dextrose, Anhydrous ..... 80 mg.  
Water for Injection ..... q.s.  
Preserved with sodium ethyl mercuri thiosalicylate 1:10,000  
Supplied with sterile disposable 1 cc. cartridge syringe.

1. Bauer, Gunnar: Nine Years' Experience with Heparin in Acute Venous Thrombosis. *Angiology*, Vol. 1, No. 2, (Apr.) 1950.

2. Smiles, William J.: Long-Acting Heparin Preparation: A Useful Adjunct in Anticoagulant Therapy. *U. S. Armed Forces Med. J.*, Vol. 11, No. 1 (Jan.) 1951.

**Upjohn**

**Research**

*for Medicine . . . Produced with care . . . Designed for health*

Trademark, Reg. U. S. Pat. Off.



THE

# Surf Rider

**A heritage from  
Old Hawaii  
becomes a symbol of  
modern hospitality**

In January Waikiki's newest hotel, the \$1,250,000 seven-story SurfRider, will open its doors. For residents and visitors alike it is an important landmark. Using local supplies and services wherever possible, it has created new jobs at home. Most important, the SurfRider means more travel trade income for all the islands. As the surfrider is a proud symbol of Hawaii's outdoor pastimes, with this hotel Matson hopes to make the name an equally proud symbol of island hospitality.



## THE SURFRIDER

☆☆☆☆☆☆☆☆☆☆☆☆☆☆☆☆

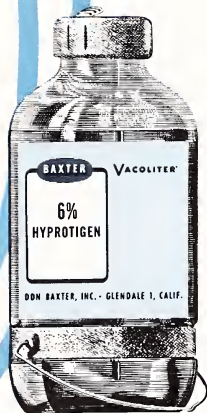
MATSON LINES



## INDEX TO ADVERTISERS

	PAGE		PAGE
Abbott Laboratories .....	118	Parke, Davis & Company.....	66, 67
Ayerst, McKenna & Harrison .....	70	Pet Milk Company .....	77
Borden Company .....	82	Chas. Pfizer & Company.....	69, 119
Carnation Company .....	78	Philip Morris & Co., Ltd., Inc. ....	76
Dairymen's Association, Ltd. ....	116	Sandoz Pharmaceuticals .....	74
Don Baxter, Inc. ....	127	Schering Corporation .....	121
Eli Lilly & Company.....	65, Insert	Schiffelin & Company .....	114
Ethicon Suture Laboratories, Inc.....	Insert	Schuman Carriage Company .....	79
Hawaiian Electric Company .....	120	Searle & Company .....	115
Home Insurance Company .....	74	Squibb & Sons .....	123
Hotel Import Company .....	117	Upjohn .....	124, 125
Lederle Laboratories, Inc. ....	75	Wadsworth's .....	106
Matson Lines .....	126	Wander Company .....	73
McArthur & Summers .....	80	Winthrop-Stearns, Inc. ....	71
Mead Johnson & Company .....	128	Wyeth, Inc. ....	68, 122
Merck & Company, Inc. ....	72		

**6% HYPROTIGEN<sup>®</sup>**  
represents more  
protein per liter than  
any of the 3 leading  
protein hydrolyzates  
for parenteral use  
...yet Hyprotigen  
costs no more



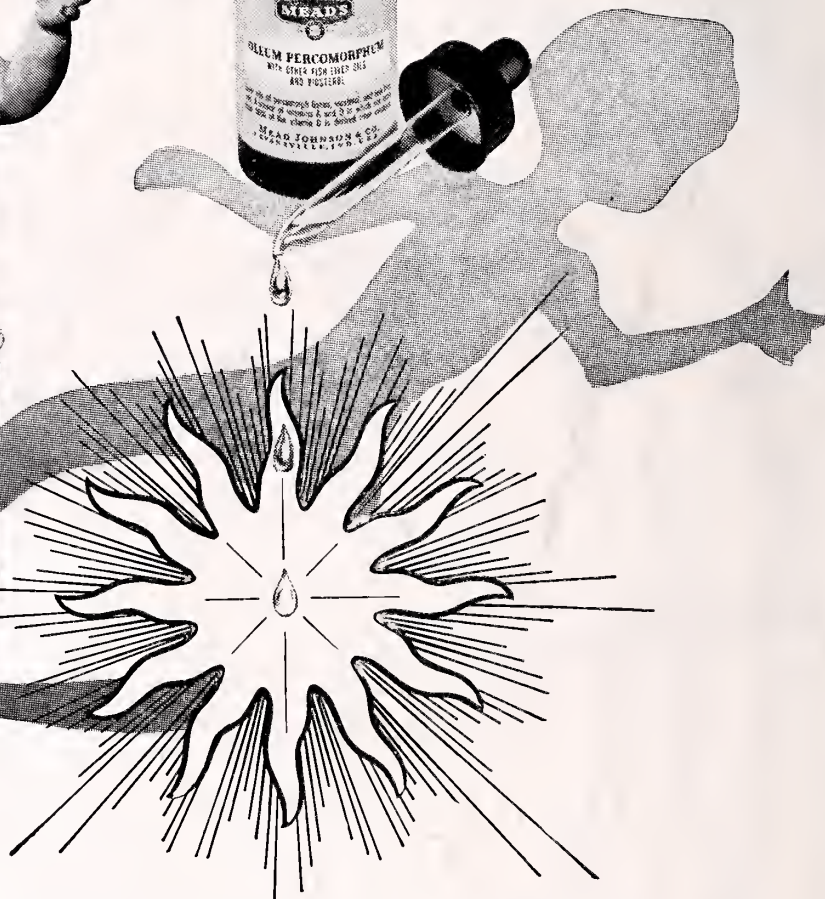
**BAXTER**

**DON BAXTER, INC.**  
Research and Production Laboratories  
Glendale 1, California

*In addition to the usual rigid tests, each lot of  
Hyprotigen is subjected to clinical tests before release.*

**Territorial Distributors:**  
**CROCKETT SALES COMPANY**  
P. O. Box 3017, Honolulu, T. H., Phone 6-8992





# D

ispels the ever-lurking shadow

Even in America today, surveys of certain groups have revealed a disturbing incidence of rickets.

Physicians realize the danger of this ever-lurking shadow, and the need for *regular, reliable protection*.

They know, too, that for most patients this protection must be economical.

That is why, *for seventeen years*, they have written so many millions of prescriptions for Mead's Oleum Percomorphum.

No other vitamin product has ever had such a background of clinical evidence.

And rarely does the physician have such *assurance* at the tip of his pen.

R  
 Doctor... remember to specify *Mead's*  
*Oleum Percomorphum*

**MEAD'S**

**MEAD JOHNSON & CO.**  
 EVANSVILLE 21, IND., U.S.A.

# HAWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

11

JANUARY-FEBRUARY, 1952

NUMBER 3

GRANT LIBRARY  
FEB 27 1952  
LIBRARY

SUBDURAL HEMATOMA IN INFANTS John J. Lowrey.....	145
OBSTRUCTIVE PNEUMONITIS OF THE MIDDLE LOBE Joseph E. Ferkany.....	149
INVOLUTIONAL MELANCHOLIA Kenneth H. Rusch.....	152
FEATURES .....	155
INTER-ISLAND NURSES' BULLETIN.....	171

*"—and, Doctor, it is contraindicated in—"*

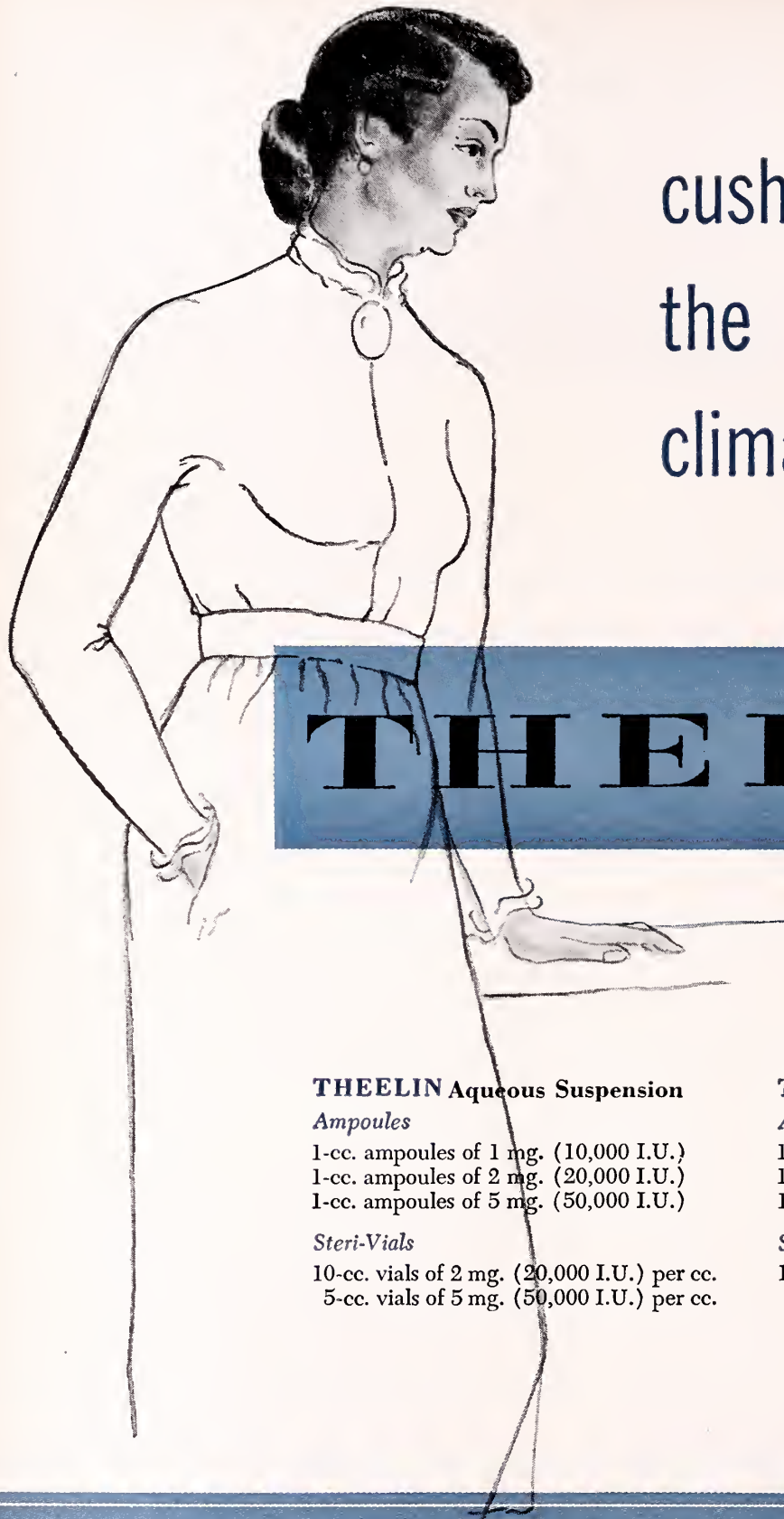
Whenever a Lilly representative visits physicians, he gives useful facts about prescription products—without varnishing the truth. Because recognizing the limitations of drugs is often as important as knowing their beneficial effects, every Lilly representative regularly presents both sides of the picture.

*He and his company are always aware  
that integrity in business is good business.*

*Lilly*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.





cushions  
the  
climacteric

# THEELIN

## **THEELIN Aqueous Suspension**

### *Ampoules*

- 1-cc. ampoules of 1 mg. (10,000 I.U.)
- 1-cc. ampoules of 2 mg. (20,000 I.U.)
- 1-cc. ampoules of 5 mg. (50,000 I.U.)

### *Steri-Vials*

- 10-cc. vials of 2 mg. (20,000 I.U.) per cc.
- 5-cc. vials of 5 mg. (50,000 I.U.) per cc.

## **THEELIN in Oil**

### *Ampoules*

- 1-cc. ampoules of 0.2 mg. (2,000 I.U.)
- 1-cc. ampoules of 0.5 mg. (5,000 I.U.)
- 1-cc. ampoules of 1 mg. (10,000 I.U.)

### *Steri-Vials*

- 10-cc. vials of 1 mg. (10,000 I.U.) per cc.

**PARKE, DAVIS & COMPANY**

THEELIN, (ketohydroxyestratriene) the first estrogen to be isolated in pure crystalline form and the first to assume clinical importance, is invaluable for alleviating the distress of the menopause and other estrogen deficiency states. A naturally-occurring estrogen, THEELIN relieves symptoms promptly *and* imparts a sense of well-being. Moreover, its notable freedom from side effects has long been familiar to physicians everywhere. Over two decades of clinical use and more than 400 references in the literature attest to its effectiveness.

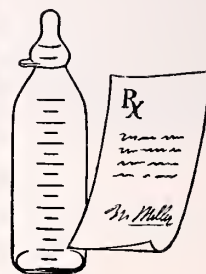
The physical properties of THEELIN — solubility in oil and insolubility in water — have been utilized to prepare forms for administration that facilitate versatile therapy. THEELIN IN OIL is rapidly absorbed from the injection site. Absorption of THEELIN AQUEOUS SUSPENSION is slower and more sustained; the therapeutic effect, therefore, is produced over a longer period of time.

Both THEELIN IN OIL and THEELIN AQUEOUS SUSPENSION are available not only in individual ampoules, but also in Steri-Vials® for greater economy.

DETROIT 32, MICHIGAN







## So much depends on the right start

Many physicians find that Pet Milk for routine first feeding of infants is a valuable prophylactic measure in avoiding sensitization to milk.

Food allergens are likely to be troublesome early. This is especially true of babies who have inherited a tendency to develop allergies.

Pet Evaporated Milk helps to avoid this problem. Heat sterilization re-

moves whey proteins from solution so that they are not immediately absorbed, undigested, into the blood stream. Instead, they are retained in the gastro-intestinal tract until digested and are then absorbed as harmless amino acids.

To help assure the right start, to help avoid feeding problems later on, use Pet Milk as the first food for infants in your care.

**FAVORED FORM  
OF MILK FOR  
INFANT FORMULA**



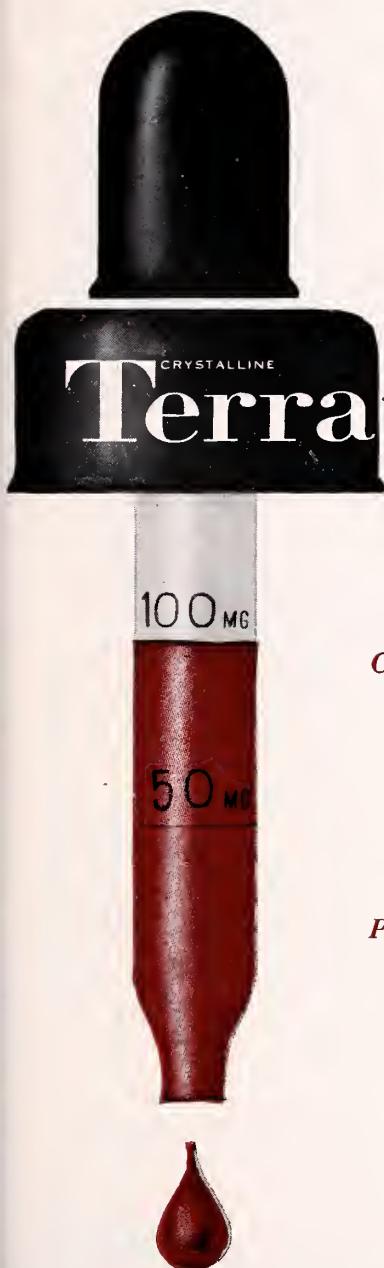
**PET MILK COMPANY, 1424-A Arcade Building, St. Louis 1, Missouri**

# THE ONLY ONE IN ORAL DROPS

# IR

*only Terramycin in liquid  
concentrate for optimal convenience*

Crystalline Terramycin Hydrochloride Oral Drops provide 50 mg. in each 9 drops—or 200 mg. per cc.—a concentration affording optimal simplicity and convenience in dosage.



## Terramycin

CRYSTALLINE  
HYDROCHLORIDE

**ORAL DROPS**

*Can be taken "as is" or mixed with foods and fluids*

These potent drops for oral administration are completely miscible with most foods, milk and fruit juices, thus permitting a further simplification in the therapeutic regimen.

*Pure crystalline antibiotic—well tolerated*

Terramycin Oral Drops are prepared from pure crystalline material. As with other dosage forms of this effective broad-spectrum antibiotic, Terramycin Oral Drops are well tolerated.

*Supplied:* 2.0 Gm. with 10 cc. of diluent, and specially calibrated dropper.

ANTIBIOTIC DIVISION



CHAS. PFIZER & CO., INC., Brooklyn 6, N. Y.





## All Children Can Benefit from *this* Protective Hot Drink at Breakfast

In its widely distributed leaflet No. 268, "Eat a Good Breakfast," the U. S. Dept. of Agriculture states: "Summer or winter, there's something hot, as a rule, in a good breakfast. . . . Something hot is cheering and tones up the whole digestive route."



The problem of encouraging children to eat an adequately protective breakfast finds easier solution when Ovaltine in hot milk is recommended as a breakfast beverage. Many children clamor for a hot drink at the morning meal, and hot Ovaltine is the right kind of drink to recommend.

A cup of hot Ovaltine makes an excellent contribution of virtually all essential nutrients, adding substantially to the nutritional start for the day. It also serves in a gustatory capacity by enhancing the appeal of breakfast and making other foods more inviting.

The nutrient contribution made by a cup of Ovaltine is apparent from the table below. Note the wealth of essentials added to the nutritional intake by making the simple recommendation of adding a cup of hot Ovaltine to the child's breakfast.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILLINOIS

# Ovaltine

Here are the nutrients that a cupful of hot Ovaltine, made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk,\* provides:

PROTEIN. . . . .	10.5 Gm.	IRON . . . . .	4 mg.	NIACIN. . . . .	2.3 mg.
FAT . . . . .	10.5 Gm.	COPPER . . . . .	0.2 mg.	VITAMIN C . . . . .	10 mg.
CARBOHYDRATE . . . . .	22 Gm.	VITAMIN A . . . . .	1000 I.U.	VITAMIN D . . . . .	140 I.U.
CALCIUM . . . . .	370 mg.	VITAMIN B <sub>1</sub> . . . . .	0.39 mg.	CALORIES . . . . .	225
PHOSPHORUS . . . . .	315 mg.	RIBOFLAVIN . . . . .	0.7 mg.		

\*Based on average reported values for milk.

*Respected as a Doctor....*

*Loved as a Doctor....*

*Dependable as a Doctor....*

IT'S



The car of mechanical perfection  
for the  
medical profession

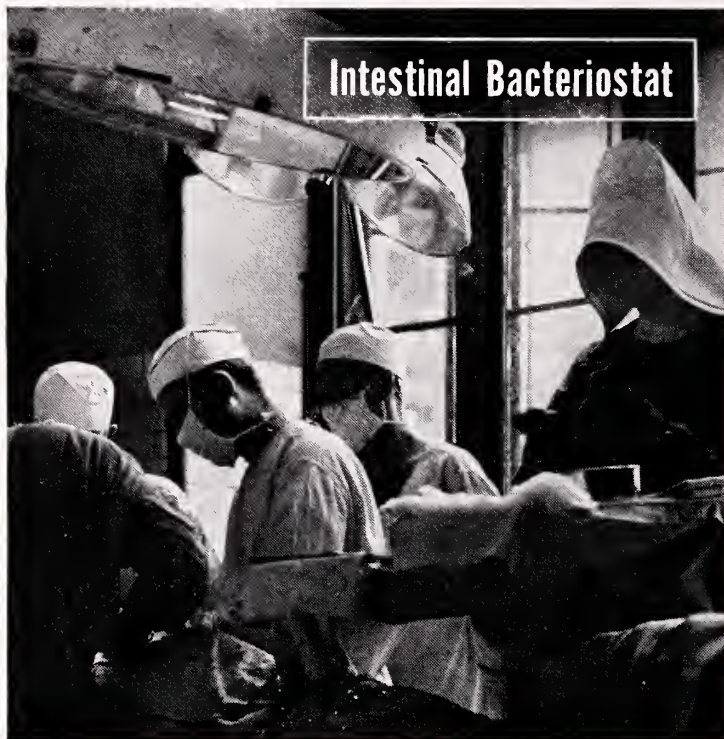


**SCHUMAN CARRIAGE COMPANY**

Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU



# Medication reduces risk of Peritonitis



Improved surgical technics have lowered the risk of peritonitis greatly; preoperative administration of SULFASUXIDINE® reduces it even further; and postoperative use of this highly efficient bacteriostat speeds and simplifies convalescence.

## SPEEDS CONVALESCENCE



**Description:** Relatively nontoxic; sparingly absorbed into blood; rapidly excreted by kidneys. Maintains high bacteriostatic concentration in bowel.

**Indications:** (1) Before intestinal surgery, to minimize risk of peritonitis; afterward, to speed and simplify recovery. (2) Ulcerative colitis. (3) Bacillary dysentery, acute or chronic, including carrier state. (4) Combats

urinary tract infections due to *E. coli*, by lowering enteric bacterial reservoir.

**Dosage:** Initial, 0.25 Gm. per kilogram of body weight; maintenance, 0.25 Gm. per kilogram per day, 6 equal doses, 4-hour intervals. Supplied in 0.5 Gm. tablets, bottles of 100, 500, 1,000, and (oral) powder, ¼ and 1 lb. bottles.

Sharp & Dohme, Philadelphia 1, Pa.

# SULFASUXIDINE

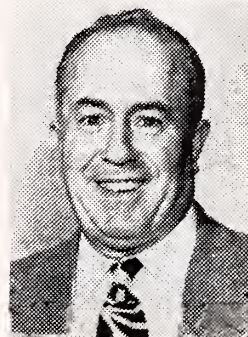
succinylsulfathiazole

THEODORE H. DAVIES CO., HONOLULU • SOLE DISTRIBUTORS

# 6/ really relax on the **LURLINE** 99

says **JOSEPH M. CLEMENTE**

*Retired Mechanic of Honolulu*



"There's just no travel like it,"

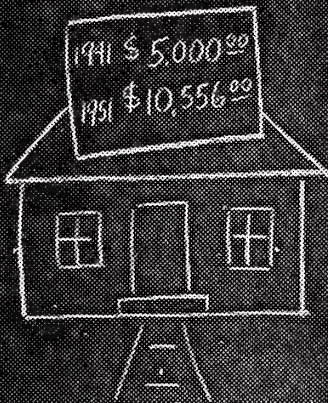
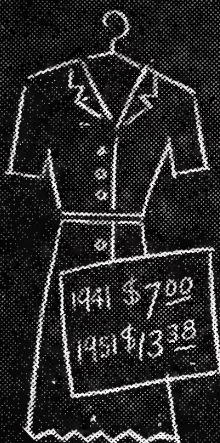
Mr. Clemente said after his recent voyage. "We rested, had fun, met new friends, and the food and service were wonderful."

Best of all, you'll find all this and more, is *included* in your LURLINE fare, the biggest bargain in mainland travel.



## Matson Lines

1021 Bishop Street  
2347 Kalakaua Ave.  
Phone 5-0945



**FATHERS, TOO,  
ARE WORTH  
MORE NOW!**

*A Wise New Year  
Resolution for  
Professional Men . . .*

**"I will ask a  
New England  
Mutual Career  
Life Underwriter  
to appraise my  
Insurance Estate"**

Telephone 6-3521

**Home Insurance Co.  
of Hawaii, Ltd.**

*Life Department*  
GENERAL AGENT



**SAFEST, SUREST, LEAST EXPENSIVE**

*Protection*  
**AGAINST ANY  
 DIETARY DEFICIENCY**



A quart a day of fresh, whole milk. Easy to recommend . . . easy to follow . . . a pleasant, natural, and really economical way to round out *every* diet. Fresh milk is known as nature's own protective food because it provides a balance of food elements that protect against deficiencies—food values that otherwise might be missed consistently, over a long period of time!

**Dairymen's**

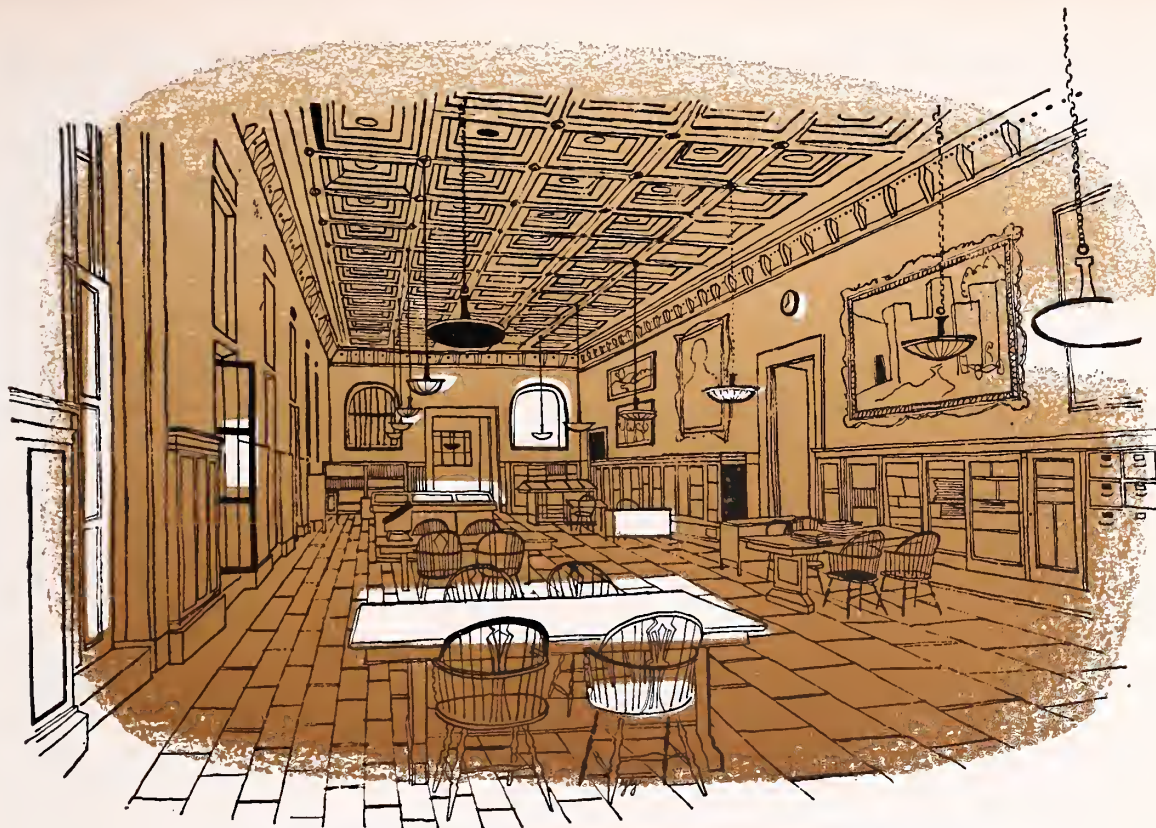
*Rich, Fresh Whole Milk Products*

GRADE AA CREAM-TOP MILK  
 GRADE AA HOMOGENIZED MILK  
 DARI-RICH CHOCOLATE MILK  
 NON-FAT MILK

GOLDEN GUERNSEY PREMIUM  
 MILK ( $\frac{1}{3}$  richer than territorial  
 requirement)  
 BUTTERMILK

**DAIRYMEN'S ASSOCIATION, LTD.**

A Division of Creameries of America, Inc.



*From among all antibiotics, Internists often choose*

# AUREOMYCIN

*Hydrochloride Crystalline*

*because*

Aureomycin readily passes into the blood stream, whence it diffuses rapidly into all the tissues and fluids of the body.

Aureomycin is a broad spectrum antibiotic that has been shown to be effective in a wide variety of infections of bacterial, rickettsial and large viral origin.

Aureomycin has been reported to be effective in

Acute Amebiasis  
Anthrax  
Acute Brucellosis  
Chancroid  
Shigella Dysentery  
Endocarditis\*  
Erysipelas  
Granuloma Inguinale

Hepatic and Biliary  
Tract Infections\*  
Influenza  
Leptospirosis  
Lymphogranuloma Inguinale  
Pericarditis\*  
Psittacosis  
Q Fever  
Rat-Bite Fever  
Relapsing Fever

Respiratory Infections\*  
Rickettsialpox  
Septicemia\*  
Rocky Mountain Spotted Fever  
Boutonneuse Fever  
Tick-Bite Fever  
Typhus  
Tick Typhus  
Tularemia

\*When caused by Aureomycin susceptible organisms.

*Throughout the world as in the United States, aureomycin is recognized as a broad spectrum antibiotic of established effectiveness.*

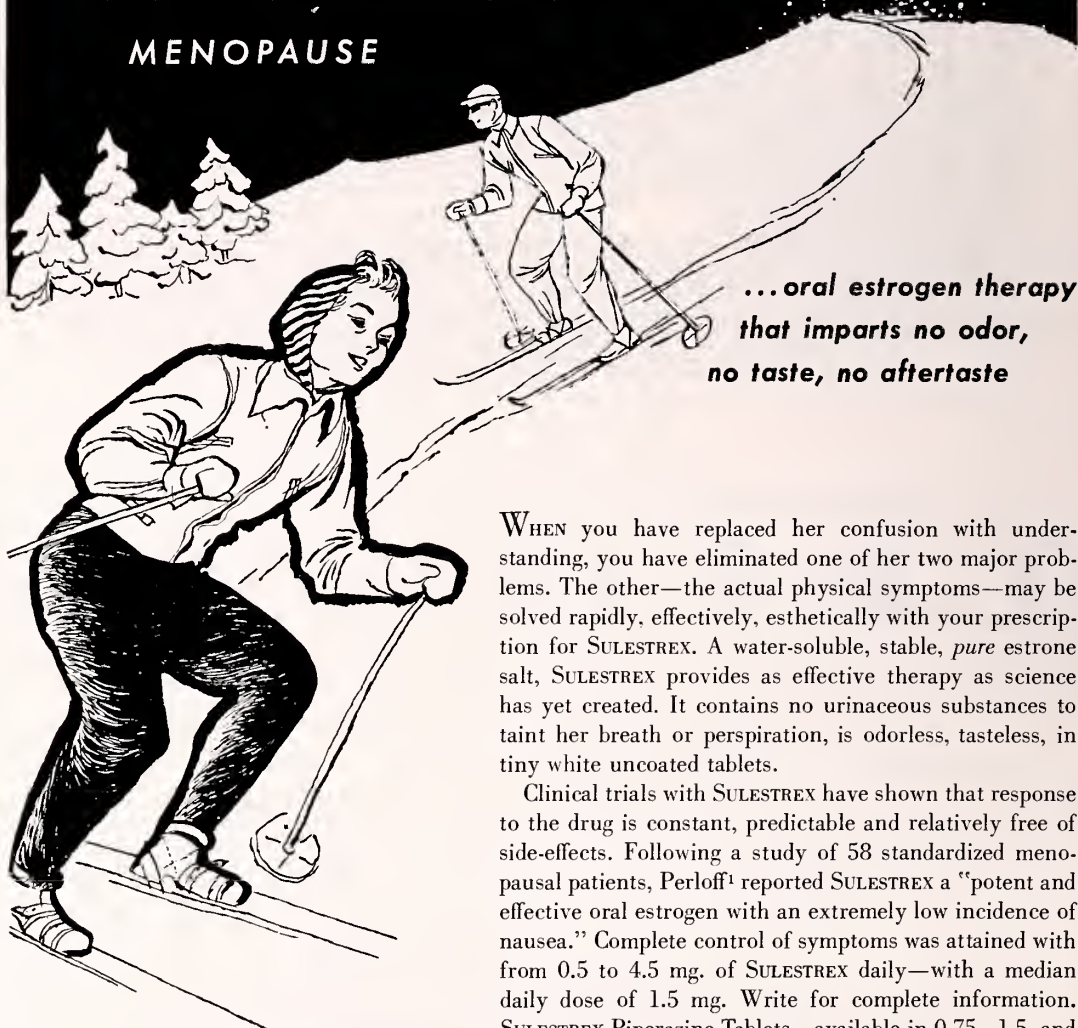
*Capsules:* 50 mg.—Bottles of 25 and 100. 250 mg.—Bottles of 16 and 100.

*Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.



# Still leading the active life -

RIGHT THROUGH THE  
MENOPAUSE



...oral estrogen therapy  
that imparts no odor,  
no taste, no aftertaste

WHEN you have replaced her confusion with understanding, you have eliminated one of her two major problems. The other—the actual physical symptoms—may be solved rapidly, effectively, esthetically with your prescription for SULESTREX. A water-soluble, stable, *pure* estrone salt, SULESTREX provides as effective therapy as science has yet created. It contains no urinous substances to taint her breath or perspiration, is odorless, tasteless, in tiny white uncoated tablets.

Clinical trials with SULESTREX have shown that response to the drug is constant, predictable and relatively free of side-effects. Following a study of 58 standardized menopausal patients, Perloff<sup>1</sup> reported SULESTREX a "potent and effective oral estrogen with an extremely low incidence of nausea." Complete control of symptoms was attained with from 0.5 to 4.5 mg. of SULESTREX daily—with a median daily dose of 1.5 mg. Write for complete information. SULESTREX Piperazine Tablets—available in 0.75-, 1.5- and 3.0-mg. potencies—are at all pharmacies.

Abbott Laboratories, North Chicago, Illinois. **Abbott**

1. Perloff, Wm. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.

**Sulestrex**  
TRADE MARK

**Piperazine Tablets**  
(PIPERAZINE ESTRONE SULFATE, ABBOTT)

No other bulk container  
for intravenous therapy  
is as safe as

VACOLITER®

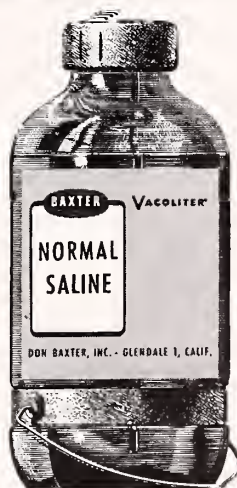


For Greater Patient Protection...

**BAXTER**

Specialists in Parenteral Therapy for Over 20 Years

**VACOLITER®**



DON BAXTER, INC. • RESEARCH AND PRODUCTION LABORATORIES • GLENDALE 1, CALIFORNIA

Territorial Distributor:

CROCKETT SALES COMPANY

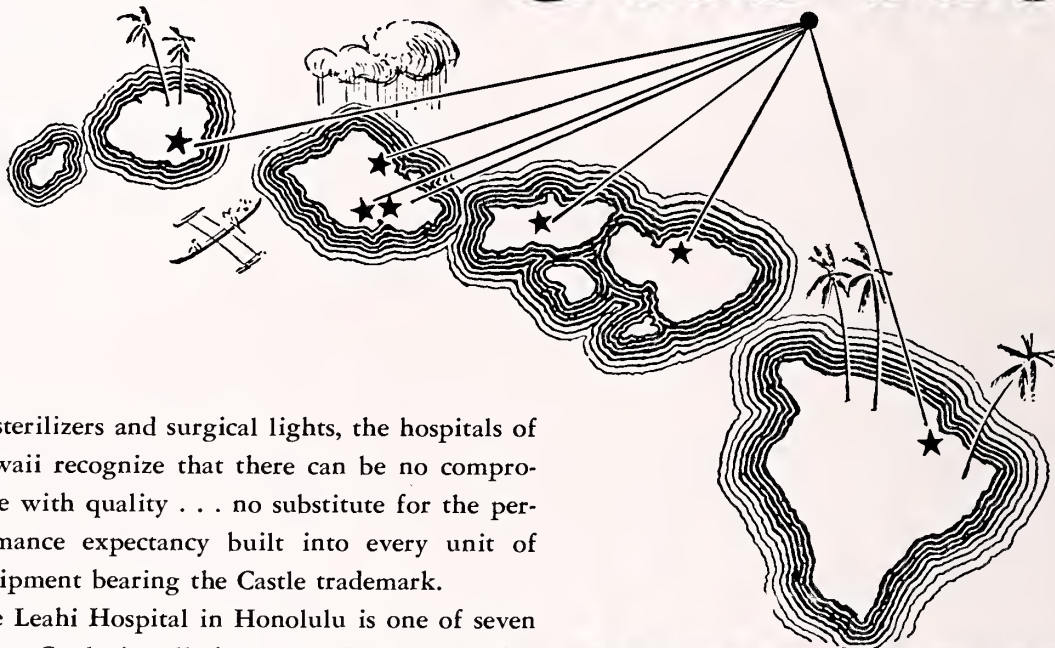
P. O. Box 3017

Honolulu, T. H.

Phone 6-8992



# Hawaii goes *Castle*



In sterilizers and surgical lights, the hospitals of Hawaii recognize that there can be no compromise with quality . . . no substitute for the performance expectancy built into every unit of equipment bearing the Castle trademark.

The Leahi Hospital in Honolulu is one of seven major Castle installations recently made in this vitally important part of our country.



## **To Hospital Architects and Consultants:**

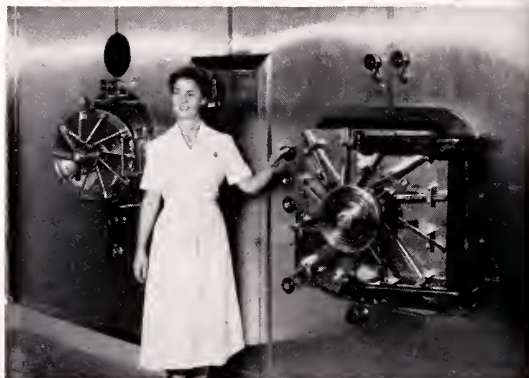
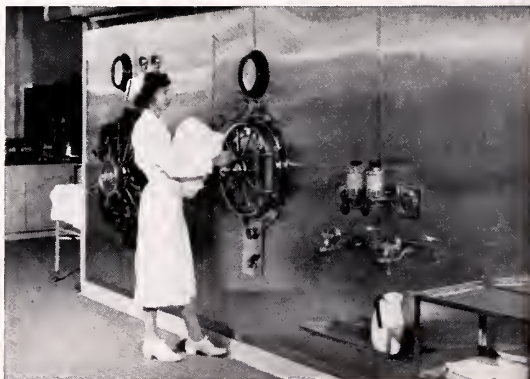
We offer the experienced know-how of our Planning Department as a gratis service. We welcome the opportunity to aid in the development of any project ranging from a small sub-sterilizer room to a large medical center.

## **HOTEL IMPORT COMPANY**

*Wholesale Druggists and Hospital Purveyors*

Division of the Von Hamm-Young Company, Ltd.

Cooke and Kawaiahao Streets



# *Castle*

**STERILIZERS AND LIGHTS**

# HAWAII MEDICAL JOURNAL

and

## INTER-ISLAND NURSES' BULLETIN

Volume 11  
Number 3

JANUARY-FEBRUARY, 1952

\$2.00 per year  
35c per copy

Published Bi-Monthly by  
**THE HAWAII TERRITORIAL MEDICAL ASSOCIATION**  
(Incorporated in 1856 under the Monarchy)

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

**THE HAWAII TERRITORIAL MEDICAL ASSOCIATION**  
1951-1952

### OFFICERS

HARRY L. ARNOLD, JR., Honolulu.....	President
R. J. MCARTHUR, Wailuku, Maui.....	President-Elect
T. DAVID WOO, Pepeekeo.....	Vice-President from Hawaii County
JOHN W. DEVEREUX, Honolulu.....	Vice-President from Honolulu County
K. K. FUJII, Kapaa.....	Vice-President from Kauai County
E. T. SHIMOKAWA, Lahaina.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

### COMMITTEE CHAIRMEN

GROVER A. BATTEN.....	Cancer Committee
TELL NELSON.....	Health Education Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	HAWAII MEDICAL JOURNAL
F. D. NANCE.....	By-Laws Committee
JOHN W. DEVEREUX.....	Advisory Board for Woman's Auxiliary
MORTON E. BERK.....	Scientific Works Committee
ISAAC A. KAWASAKI.....	Public Service Committee
VERNE C. WAITE.....	Post-Graduate Committee
SAMUEL YEE.....	Legislative Committee

### OFFICERS — COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....T. David Woo, Pepeekeo	John W. Devereux	K. K. Fujii, Kapaa	Edw. T. Shimokawa, Lahaina
<i>Vice-President</i> .....S. Kasamoto, Hilo	Wm. M. Walsh	Keith Kuhlman, Koloa	John A. Burden, Paia
<i>Secretary</i> .....Francis Wong, Hilo	Wm. S. Ito	C. H. Ishii, Lihue	Edward Kushi, Wailuku
<i>Treasurer</i> .....Richard Hata, Hilo	C. M. Burgess	C. H. Ishii, Lihue	Edward Kushi, Wailuku

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1951, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.





# Rx "Prescription for Good Growth"

For proper body growth and tissue development, it is imperative that infants have ample protein in the early months of life.

With DRYCO, you have an ideal infant food to recommend—a food that meets special protein demands and, in fact, closely approximates the other nutritional and digestional advantages of breast milk.

DRYCO has a 2.7 to 1 ratio of protein to fat. Thus it compensates for the biological differences between cow's milk and human milk proteins to give infants an adequate supply of this "priority" food element. An additional feature of DRYCO's lower fat content is the fact that vomiting, indigestion and constipation often caused by excessive fat are reduced.

To ensure best nutrition, DRYCO has been fortified with vitamins A and D. All DRYCO formulas supply adequate amounts of vitamins A, B<sub>1</sub>, B<sub>2</sub>, and D for the normal infant.

The moderate amount and type of carbohydrate required by each case. DRYCO is easy to prepare... the mother simply dissolves DRYCO in cool, previously boiled water to which carbohydrate has been added. In every sense then, it is an ideal infant food.

Remember, DRYCO provides ideal nutrition for the normal infant. That makes it an excellent product for you to recommend.

VITAMIN FORTIFIED  
**DRYCO**



Copr. 1951  
Borden Co. Prop.  
Intellectual Res.



More data available on request to:  
THE BORDEN COMPANY, Export Division  
350 Madison Avenue, New York 17, N. Y., U.S.A.



44T

# Subdural Hematoma in Infants

## Diagnosis, Management and Report of Six Cases

JOHN J. LOWREY, M.D.  
HONOLULU



DR. LOWREY

UNTIL recently the frequency of subdural hematoma in infancy was not appreciated and there was no standardized method of treatment. Today a relatively simple and safe method of diagnosis is available, so that interested pediatricians and surgeons can make a positive diagnosis. And a combination of early conservative and later radical treatment has proven to be effective and safe. The result of delayed or inadequate treatment is a baby with cerebral atrophy and mental retardation.

In 1930 Sherwood<sup>1</sup> reported 9 cases of subdural hematoma in infancy observed over a period of nine years. In 1939 Ingraham and Heyl<sup>2</sup> reported the cases of 11 patients treated in the previous year at The Children's Hospital, Boston, according to a standard program. In 1944, Ingraham and Matson<sup>3</sup> reported the patients treated up to 1944 according to the above plan. The series then numbered 98 patients and has since grown to 300. The 6 patients to be reported here were all treated according to this program.

### Etiology and Pathology

Trauma is undoubtedly the most important cause of subdural hematoma and occurred in all the patients reported here except one who had an abnormal bleeding tendency. The history of trauma is not necessarily recent and may have been forgotten. All infants probably fall a couple of times before they learn to walk, and probably every doctor at some time has taken an x-ray of a baby's skull to reassure the parents following an apparently minor fall, only to find that a fracture is present. Such a finding by x-ray proves relatively severe trauma has occurred and indicates the patient should be observed carefully. The absence of a fracture, however, does not rule out the

presence of a subdural hematoma.

In large series of patients, the highest incidence of cases occurs in the first six months, and here birth trauma may play a role. The compression and molding of the fetal head, particularly if produced rapidly, as in a precipitate delivery, can produce tearing of blood vessels with resulting hemorrhage. This was almost certainly the etiology in one patient seen at two weeks of age with a history of a difficult delivery. Systemic disease such as infection, malnutrition or lack of vitamin C may be a contributory cause, but unless it produces a grossly abnormal bleeding tendency probably never is entirely responsible for a subdural hematoma.

In subdural hematoma the site of bleeding is usually from torn veins bridging the space from cortex to sagittal sinus. This is the site where, it has been shown experimentally, the greatest shift of the brain occurs during trauma.<sup>4</sup> Also, the usual location of subdural hematomas is over the parietofrontal or parieto-occipital lobes, which is consistent with bleeding originating at the above site.

If the bleeding is sufficiently profuse death may occur in a few hours. If bleeding is less extensive, a layer of blood forms between the dura and arachnoid and the bleeding stops. This blood may remain fluid and the red cells become hemolyzed, leaving a collection of xanthochromic fluid; or the blood may clot and form an outer and inner membrane with contained xanthochromic fluid. If the latter occurs, the outer membrane rapidly becomes organized and new blood vessels grow into it from the dura, to which it is densely adherent. New blood vessels apparently can appear within three weeks, if we can date the trauma in one of these patients. The inner membrane does not adhere to the arachnoid, and new blood vessels only grow into it from the periphery, so it remains thin for a long time. It may act as a semipermeable membrane and allow fluid to be pushed from the adjacent tissues into the clot because of the higher osmotic pressure outside resulting from the proteins of the extravasated blood. This will result in delayed pressure symptoms.

Read before the Hawaii Chapter, American College of Surgeons, April 27, 1951. Received for publication August 30, 1951.

<sup>1</sup> Sherwood, D.: Chronic Subdural Hematoma in Infants, *Am. J. Dis. Child.* 39:980 (May) 1930.

<sup>2</sup> Ingraham, F. D., and Heyl, H. L.: Subdural Hematoma in Infancy and Childhood, *J.A.M.A.* 112:198 (Jan. 4) 1939.

<sup>3</sup> Ingraham, F. D., and Mason, D. D.: Subdural Hematoma in Infancy, *Jour. Ped.* 24:1 (Jan.) 1944.

<sup>4</sup> Pudenz, R. H., and Sheldon, C. H.: The Lucite Calvarium—A Method for Direct Observation of the Brain, *Jour. Neurosurg.* 3:487 (Nov.) 1946.



TABLE 1.—History of 6 Cases of Subdural Hematoma.

AGE	PRESENTING COMPLAINT	HEAD INJURY	CONVULSION	MALNUTRITION	ENLARGING HEAD	LETHARGY	VOMITING	ABNORMAL BLEEDING
1 N 2 wks.	fever	difficult birth						
2 K 7 mos.	convulsion	fall	×					
3 Y 8 mos.	fever vomiting							×
4 Q 8 mos.	convulsion	fall	×		×			
5 P 12 mos.	malnutrition	fall		11½ lbs.				
6 S 15 mos.	listless vomiting	fall				×	×	

The presence of an organized clot in the subdural space thus leads to an increasing mass which depresses the brain, or a tough inelastic membrane which constricts the developing brain. In adults it is usually sufficient, if the subdural hematoma is fluid, to drain the contents of the clot to cure the patient. In babies, however, a totally different situation exists. It has been estimated that the volume of brain substance is doubled in the first three months of life and doubled again in the next six months. If only the fluid portion of the clot is removed in a baby, the tough inelastic membrane will remain, and constrict and permanently injure the developing brain.

#### Diagnosis

The diagnosis of this condition depends first on an appreciation of its frequency. A history of a fall is helpful if present. The presenting problems which caused admission to the hospital in these six patients were: (1) fever since birth; (2) convulsions; (3) fever and vomiting; (4) separated sutures by x-ray; (5) malnutrition; and (6) listlessness and vomiting. A history of trauma was obtained in all but one patient. Other frequent

symptoms in these patients are infection, hyperirritability or stupor. In other words, the symptoms are those common to most illnesses in infants and do not necessarily point to the central nervous system.

The physical examination on admission showed one or more of the following findings: fever, tight fontanels, a "cracked pot" sound on percussing over the cranial sutures, blurred optic discs, unequal reflexes, spasticity, squints, lethargy, emaciation, and petechial hemorrhages. X-rays on admission showed linear fractures in two patients and separated sutures in four.

The whole clinical picture presented by these patients is usually a chronic rather than an acute affair. Occasionally, a baby is seen soon after a fall with signs and symptoms of rapidly increasing intracranial pressure, coma, vomiting and paralysis. But, possibly due to the elasticity of the infant's skull, this picture is less common than in adults, and the patients usually present the picture of a sick child with the non-localizing findings noted above.

The diagnosis of this condition can be proven

TABLE 2.—Physical Findings in 6 Cases of Subdural Hematoma.

AGE	"CRACKED POT"	TIGHT FONTANEL	TEMP.	BLURRED OPTIC DISCS	UNEQUAL REFLEXES	SPASTICITY	SQUINT	LETHARGY	EMACIATION	PETECHIAL HEMORRHAGE	X-RAY	
											FRACTURE	SEPARATED SUTURES
1 N 2 wks.		×	104			×						×
2 K 7 mos.		×	103	×	×	×					×	×
3 Y 8 mos.		×								×		
4 Q 8 mos.	×			×							×	×
5 P 12 mos.					×				×			
6 S 15 mos.	×		100				×	×				×

K required one subdural tap postoperatively.

Q required aspiration of cephalhematoma postoperatively.

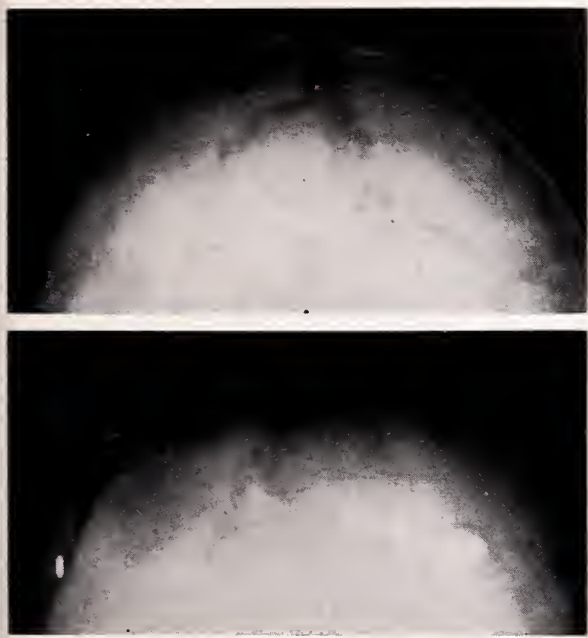


FIG. 1.—X-rays showing (above) preoperative separation of sagittal suture and (below) postoperative normal suture following removal of subdural hematoma and release of increased intracranial pressure.

only by the demonstration of xanthochromic or bloody fluid in the subdural space. Lumbar puncture in the chronic stage may be normal and in the acute stage is dangerous and contraindicated. A pneumoencephalogram may demonstrate cortical atrophy or the presence of a clot between the skull and the subarachnoid space but is not necessary for diagnosis, and these patients frequently tolerate the procedure poorly.

Subdural taps, using the proper needles and techniques, can be easily and safely performed. The anterior half of the scalp is shaved and the field thoroughly prepared with cleansing and antiseptic solutions. A drape is used to cover the posterior scalp. A wheal is then made on each side beyond the lateral limit of the anterior fontanel over the coronal suture. A sharp but short-beveled lumbar puncture needle, size 19 or 20, is then inserted through the wheal and coronal suture at right angles to the scalp. Twisting the needle with the right hand allows the operator to advance the point slowly, the depth being controlled with the fingers of the left hand. It is usually easy to tell when the dura is pierced. The stylet is then removed and if a subdural hematoma is present, fluid will flow from the needle. If no hematoma is present, it is possible with patience to obtain a couple of drops or possibly a cubic centimeter of clear fluid. Aspirating through the needle is not necessary, and it is dangerous. Advancing the

needle further than just through the dura may penetrate the brain and is potentially dangerous. Scrupulous sterile technique must be observed, as a hematoma is a good culture medium and infection in this location is disastrous.

#### Treatment

The beginning of treatment actually is the diagnostic tap. The rationale of treatment is first, slow drainage of the fluid portion of the hematoma; second, the determination of the presence or absence of a subdural membrane; and third, the radical removal of portions of the membranes. The drainage of the fluid is accomplished by daily subdural taps, alternating sides if bilateral hematomas are present. No more than 20 cc. is withdrawn at a single session as these babies tolerate poorly the sudden release of pressure. During this stage of treatment the general condition of the patient is improved with blood transfusions or whatever treatment is indicated.

When the condition of the patient is stabilized, bilateral subtemporal burr holes are made under general anesthesia. This procedure is to establish the presence or absence of a hematoma membrane and should routinely be done bilaterally because of the high incidence of bilateral clots. While



FIG. 2.—Subdural hematoma membranes. Above, thin rolled-up inner membrane; below, thick multilayered outer membrane.



the dura is open, any xanthochromic fluid discovered is washed out with isotonic-saline solution. If no membrane is found, this completes the treatment. If a membrane is found after an interval of five to seven days, the third stage can be undertaken.

The third stage necessitates the elevation of a bone flap. It requires all the necessary equipment and aids of modern neurosurgery and scrupulous attention to the details of technique and fluid balance, so important in operations on infants. Such an operation should never be undertaken

dura is filled with saline and closure carried out in layers with fine silk.

Postoperatively, the patients require careful attention to maintaining their fluid balance, controlling the body temperature, preventing restlessness and pressure areas, maintaining position of the head and re-establishing normal bodily functions. The intravenous cannula is often best left in place for twenty-four hours.

Under this regimen of treatment, a good prognosis can be expected in about 75 per cent of cases, according to Ingraham and Matson. Ob-

TABLE 3.—*Summary of Treatment of 6 Personally Treated Cases.*

	SUBDURAL TAPS		BURR HOLES		CRANIOTOMY	
	<i>Right</i>	<i>Left</i>	<i>Right</i>	<i>Left</i>	<i>Right</i>	<i>Left</i>
1 N	Xantho	Xantho	0	Xantho		
2 K	Xantho	Xantho	Membrane	Fluid	Membrane & Fluid	
3 Y	Clear	Xantho	Excessive clear fluid	Membrane		
4 Q	Xantho	Neg.	Membrane	Normal	Membrane & Fluid	
5 P	Neg.	Xantho		Membrane		Multilayered clot
6 S	Neg.	Neg.	Normal	Membrane		Membrane & Fluid

All developing normally to date.

without a constant intravenous drip so that blood replacement can be given when necessary. The operation is done preferably under general anesthesia.

A medium sized osteoplastic bone flap is elevated over the site of the hematoma. In the smaller infants the skull can often be cut with scissors. The dura is then laid back. If possible, the adherent outer membrane is peeled off, but at times the membrane may come away with the dura. When the dura is laid back, the remaining membrane is peeled off its under surface. All exposed membrane is then trimmed away and the contents, if any, washed out with saline. The inner membrane is then teased off the arachnoid. It is not necessary to remove all bits of membrane at the periphery of the hematoma, and too vigorous attempts to do so may start brisk hemorrhage or promote postoperative oozing, both of which are undesirable. Apparently, from the excellent long-term results reported by Ingraham and Matson,<sup>3</sup> if the central portion of the membrane is removed and its continuity destroyed, constriction of the developing brain will not occur. When the entire field is free of any oozing, any cavity under the

viously the prognosis depends on how early the patient is seen. If severe atrophy is already present at the time of operation, the outlook is less hopeful, but even so, the improvement following surgery may be very gratifying.

#### Summary

The etiology, signs, symptoms, diagnosis and treatment of infants with subdural hematomas are discussed.

Charts showing in summary the history, physical findings and treatment of 6 patients treated in the past two years are included.

The relative frequency of the condition, the poor prognosis in untreated cases, and the favorable prognosis in properly treated cases, are stressed.

#### Addendum

Since this paper was read, patient No. 3 has been seen again for convulsions and a hemiparesis. In view of the known bleeding tendency he manifests, operation has not been recommended even though the presence of a hematoma membrane has been established.

# Obstructive Pneumonitis of the Middle Lobe

## "The Middle Lobe Syndrome"

JOSEPH E. FERKANY, M.D.  
KULA, MAUI



DR. FERKANY

THIS condition has been described in the past few years by many authors as a new clinical entity. It has been referred to by Graham<sup>1</sup> as "the middle lobe syndrome," by Paulson and Shaw as chronic atelectasis and pneumonitis of the middle lobe,<sup>2</sup> and by others as chronic pneumonitis.<sup>3</sup>

### Anatomy

For a better understanding of this condition, we should review the anatomy of the middle lobe bronchus. The middle lobe bronchus is on the anterior aspect of the right bronchi, some 3 cm. below the right upper lobe stem. It is a single stem for about 1 to 1.5 cm., then divides into two branches—a medial and lateral division.<sup>4</sup> Because of the very acute angle at which the middle lobe bronchus leaves the main bronchus, this lobe becomes vulnerable to the effects of lymph node enlargement. This encroachment, if persistent, causes the bronchus to be compressed, with resultant obstruction which leads to atelectasis and a destroyed lobe.

### Pathology

The essential pathological feature of this condition is that the lobe is always decreased in volume. Fibrous adhesions of varying density are apparent about the lobe; the bronchial lymph nodes are frequently found to be enlarged and indurated. They often surround the entire middle lobe bronchus at its origin from the intermediary bronchus. Paulson<sup>2</sup> states: "Although bronchi-

ectasis is frequently reported by the pathologist, the principal feature of the disease is obstruction of the middle lobe bronchus, with chronic atelectasis and pneumonitis." Bronchiectasis is only secondary to a long-standing bronchial obstruction.

### Symptoms

Symptoms of this condition vary, and when the patient is first seen will usually be passed off as chronic bronchitis. Chronic cough is present in all cases. Other symptoms follow—pain, hemoptysis, dyspnea and wheeze. The patient will give a history of having had pneumonia at some earlier time and may complain of a low grade fever, malaise, frequent colds and a loss of weight. The duration of symptoms may be as long as twenty years, but in the main the patients have had their presenting symptoms for over one year.

### Diagnostic Measures

These include x-rays, lipiodol studies and bronchoscopy. In addition to the conventional postero-anterior x-ray, a right lateral and left oblique x-ray are obligatory. By this means the area of increased density will usually be found in the region of the middle lobe. With lipiodol studies, complete blockage or close grouping of the bronchi will demonstrate the obstructive pneumonitis or bronchiectasis in some cases.

Bronchoscopic findings are those of edema in and about the mucosa of the middle lobe. In some cases the orifice to the middle lobe will be slit, or may appear normal. On occasions pus can be seen coming from the orifice.

A diagnosis of this condition necessitates a careful history, with bronchoscopic, roentgenographic and bronchographic findings.

### Case Report

P. A., a 21 year old Japanese male, was seen because of persistent cough of over three years' duration. He was a pre-medical student who went to the out-patient department continuously because of frequent colds. He stated he was told he had a slight bronchitis, and was finally advised to return home and rest for six months.

He reported to his private physician in October of 1950, was hospitalized, and treated with various antibiotics, including penicillin, streptomycin and aureomycin. The diagnosis was viral pneumonia. He stated he felt better after bed rest and treatment for one week but

Received for publication July 17, 1951.

<sup>1</sup> Graham, E. A., Burford, T. H., and Mayer, J. H.: Middle Lobe Syndrome, *Postgraduate Medicine* 4:29 (July) 1948.

<sup>2</sup> Paulson, D. L., and Shaw, R. R.: Chronic Atelectasis and Pneumonitis of the Middle Lobe, *J. Thoracic Surg.* 18:747 (Dec.) 1949.

<sup>3</sup> Waddell, Wm., Sniffen, R., and Sweet, R.: Chronic Pneumonitis, *J. Thoracic Surg.* 18:707 (Oct.) 1949.

<sup>4</sup> Brock, R. C.: *Anatomy of the Bronchial Tree*, Oxford Medical Publications, 1946. Boyden<sup>5</sup>.

<sup>5</sup> Boyden, E. A., and Hamre, C. J.: An Analysis of Variations in the Broncho Vascular Patterns of the Middle Lobe in Fifty Dissected and Twenty Injected Lungs, *J. Thoracic Surg.* 21:172 (Feb.) 1951.



the cough recurred. It was worse while in the recumbent position, and he had difficulty in sleeping at night. Associated with this cough, which was slightly productive at times, he had pain over the right anterior portion of his chest. There was no history of hemoptysis, night sweats, loss of weight or dyspnea, but he thought he had an occasional wheeze. He noticed extreme difficulty in raising sputum and that it caused a "rattling" sound in his chest. When he raised sputum it was thick and mucoid, but he did not feel that it had been purulent. He had not used oily nose drops or spray. He had been hospitalized in 1947 for pleurisy of the right side of the chest.

Physical examination disclosed a well-developed, well-nourished Japanese male, not acutely ill. Complete examination revealed no abnormalities.

Laboratory findings on admission were: red cell count 5.8 million per cubic mm., hemoglobin 14.4 grams, white cells 5,100; polys 56%, stabs 8%, lymphocytes 32%, monocytes 2%, eosinophiles 2%. No acid fast bacilli were found in sputum concentrates. Other blood examinations were normal also. Roentgenograms of the chest showed only a slight haziness of the lung at the right border of the heart; they were otherwise negative.



FIG. 1.—X-ray appearance of the right chest. Note only slight increase in markings along right border of heart.

Bronchoscopy revealed a normal left bronchial tree, and on the right side the middle lobe orifice was widely patent but hyperemic and edematous. When the bronchoscope was near this orifice it set up a coughing reflex and thick mucoid sputum was visible.

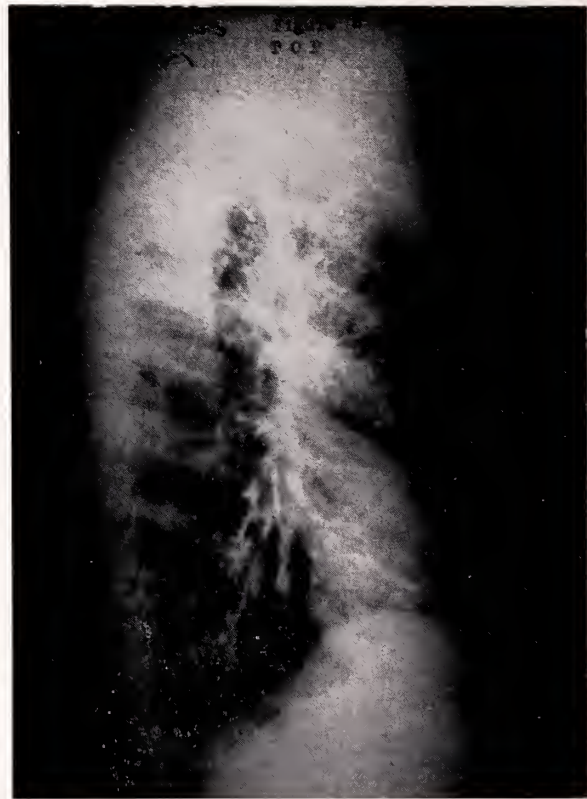


FIG. 2.—Right lateral view with lipiodol. Note area of density anteriorly and lack of filling with lipiodol.

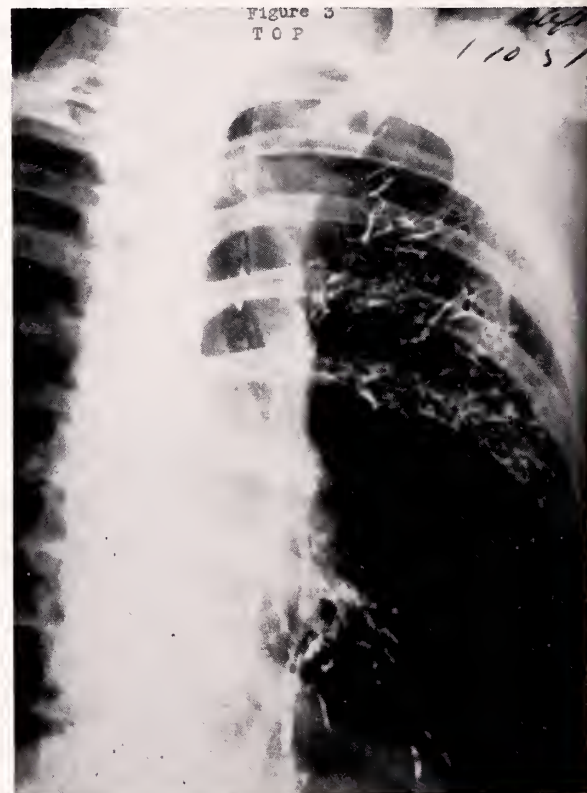


FIG. 3.—Left oblique view. Note location of obstruction in middle lobe orifice just as it bifurcates.

Lipiodol studies were then performed which demonstrated conclusively that there was obstruction of the middle lobe beyond the main stem at the bifurcation into the lateral and medial division.

Surgery was advised and the patient accepted, but was told to return in six weeks to see if the oil had been expelled or absorbed, or both.

On February 26, 1951 a right middle lobectomy was performed. On opening the chest, we found that the upper and lower lobes completely filled the entire chest cavity. The middle lobe was shrunken and "pancaked" between the upper and lower lobes. It had the consistency of a hard rubber ball and was not aerated. No glands could be palpated. Only filmy adhesions were present and these were separated quite easily by sharp and blunt dissection. The middle lobe was removed, using the individual ligation technique. It was fused to the upper lobe but no difficulty was encountered in its removal.

Postoperative convalescence was uneventful and the patient was up and about the next day. He was discharged on the seventh postoperative day.

The gross and microscopic findings reported by Dr. I. L. Tilden of The Clinic, Honolulu, were as follows:

"Gross examination showed many dilated bronchi and bronchioli filled with purulent material surrounded by compressed atelectatic appearing lung tissue.

"Microscopically the bronchi and bronchioles are greatly dilated and some of them contain acute inflammatory exudate. They are surrounded by an increased amount of connective tissue which is heavily infiltrated with lymphocytes and plasma cells. The intervening tissue shows atelectasis fibrosis in some areas and congestion manifested by a great many red cells within the alveolar spaces. There is no evidence of neoplastic changes or tuberculosis." The condition was diagnosed pathologically as chronic suppurative bronchiectasis.

This young man, four months later, is completely free of cough, is gaining weight, and is preparing to go back to school. His physical limitations are unchanged.

The x-ray taken in 1947 was of particular interest. Unfortunately, there was only one AP film, but I feel it was definitely pneumonia of the middle lobe. This could have been the initial cause of his presenting complaints.

In the past few months three similar cases have been seen; all had been followed for many years. In one case the presenting symptom was cough; the second, asthma or wheezing; the third, hemoptysis. One patient has refused surgery and the other two are undecided. Their ages range from 16 to 60.

### Discussion and Conclusion

Obstructive pneumonitis can occur in any portion of the lung but because of the mechanical factors, the middle lobe seems to be involved more frequently. The middle lobe bronchus arises almost at right angles from the intermediary bronchus and since the main stem is short it is very susceptible to obstruction by enlarging lymph nodes which surround it. Also, because of the acute angle, drainage is poor. The diameter of the two branches is small and hence easily obstructed. Inflammatory change within the bronchial lumen from pneumonia could result in changes sufficient to bring about an obstructive pneumonitis.

The diagnosis is not difficult if one is aware of the possibility. One of the most important conditions in differential diagnosis is bronchogenic carcinoma. This should be kept constantly in mind in the older age group.

Patients who present a history of chronic cough, pain in the chest, hemoptysis, wheeze or dyspnea should be given careful evaluation. Not only should a postero-anterior film be taken but other positions plus the assistance of bronchoscopy and bronchographic studies should be considered.

The treatment of obstructive pneumonitis of the middle lobe is surgical unless the age or general physical condition of the patients are contraindications.

Waiaikoa, Kula, Hawaii.

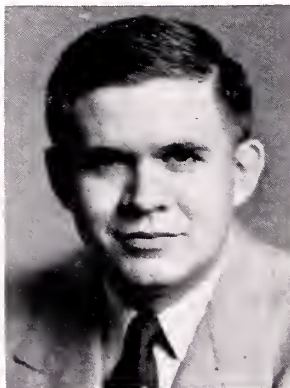


# Involutional Melancholia

KENNETH H. RUSCH, M.D.

HONOLULU

THE involutional psychoses are a common form of emotional illness in middle life. Generally they appear in women between the ages of forty and sixty, and in men between the fiftieth and sixtieth year. For the most part they occur in one of two forms, either involutional melancholia characterized by an agitated depression or a paranoid psychosis characterized by persecutory delusions. Sometimes an admixture of the two forms is seen.



DR. RUSCH

## Etiology

This emotional illness is associated with the climacteric but is not directly related to it. It is not caused by glandular changes but rather by the patient's attitude toward his changing role in life. This may be aptly illustrated in women, in whom an involutional psychosis may appear five years before there are any menstrual changes or as late as ten or fifteen years after the menopause has occurred. In contrast to this is the menopausal syndrome which not infrequently appears at the time of the menopause and apparently is caused by estrogen deficiency. The symptoms of this syndrome include the well known hot flashes, excessive sweating, headaches, irritability, and some insomnia. These symptoms are helped by estrogen therapy, and in any case almost always disappear within a year after the menopause.

The etiology of the involutional psychoses, then, is to the best of our knowledge emotional. The involutional period in life is a time when there is great need for adaptability, but this is also a time when the personality tends to have become very rigid. The person has secured a certain niche in society from which he is reluctant to emerge. His responses are more stereotyped, and he is resistive to change and new modes of life. New ideas and concepts are less apt to find a receptive ear. At this time men realize that many of their ambitions will never be fulfilled. They know they have passed their prime in physical and mental activity,

and there is a decrease in sexual potency in many. Women especially are made aware in a dramatic fashion by the appearance of the menopause that their period of biological usefulness has ended. They may come to the painful realization that they will never have the children they have postponed; they may feel that their life has been empty and barren. In addition, both sexes begin to note that lifelong friends of their own age have serious illnesses or are dying. Children to whom they have devoted the major portion of their interests for many years are leaving the home to live their own lives. In many there is the spectre of financial insecurity in old age.

All people in middle life must face some of these problems. However, those who become ill with an involutional psychosis have a number of personality characteristics in common which seem to predispose them to making this transition in life less easily than others. These persons are often very meticulous, overly conscientious, and fussy in nature. They may have narrow interests and are often intolerant in their views. Many times they have made a poor sexual adjustment and are markedly sensitive in their relationships with others. Often they have been thrifty all their lives. They have difficulty in maintaining lasting friendships, and often lack a sense of humor and easy sociability. However, very commonly a person who becomes ill has been a faithful servant in a job which he has held for many years.

These personality characteristics are in turn usually traceable to patterns of reaction developed as the result of emotional experiences in the formative years. The importance of the family relationships in childhood cannot be overemphasized in discussing the etiology of this illness. Rigid parents who demand that their children be ultra-conforming, who fail to give their children a natural approach to the understanding of sex, who are impersonal or even rejecting in their relations with their children may be laying the groundwork for a nervous disorder many years later.

## Clinical Course

Before an involutional psychosis appears there may be a precipitating incident, as mentioned previously, or there may be none. The onset may be very insidious and may be characterized by many hypochondriacal complaints. For this reason, the patient will most often be taken to the general

From the office of R. D. Kepner, M.D.  
Received for publication July 26, 1951.

practitioner rather than to a psychiatrist. Constipation is a common feature, and there may be anorexia and weight loss as well. Sleeplessness is frequently an accompanying complaint. Agitation and depression, sometimes not prominent at first, may become gradually more apparent, and there may be periods of weeping for no visible reason.

In the series of fifty-eight cases reported here, the somatic complaints were many and varied. Following is a partial list of somatic and other complaints: Burning, perineal cramping, bad taste in mouth, epigastric pain, obstruction of the stomach, cancer of the throat, "pain head to toe," crawling sensations, "already dead," hot and cold feelings in the abdomen, constipation, occipital headaches, heart not working right and stopping at times, eyes failing, weight loss, and cancer. Because of the prominence of somatic complaints, especially related to the gastrointestinal tract, it is important to consider involutional melancholia in the differential diagnosis when a middle-aged patient appears with ill-defined and somewhat bizarre somatic complaints.

As the disease unfolds, the agitation and depression increase. Nihilistic delusions, when the patient believes that a member of the family or he himself is dead, are common. There is extreme self-deprecation. The patient desires to confess what he considers to be unpardonable sins in the past. These are usually long forgotten minor infractions of little consequence. He feels that all is hopeless, that he should be jailed and put to death. He is inconsolable and reassurance is futile.

Many of the patients are actively suicidal and will make vigorous attempts to harm themselves. In our series of fifty-eight cases, five made desperate suicide attempts. One suffered severe lacerations of the neck involving the trachea. Another, because he believed he had not had a bowel movement for several months, slashed open his abdomen to remove the fecal material that way. A third made an attempt in the hospital to strangle himself with a sheet. The fourth suffered a severe barbiturate poisoning which required intensive analeptic treatment for forty-eight hours. The fifth had also taken a quantity of barbiturates and turned on the gas in a Waikiki apartment. This patient had come to Hawaii for a vacation a short time earlier in hopes that a vacation might make her feel better.

Treatment

In the treatment of involutional melancholia closely supervised confinement in a hospital is essential to guard against this obvious suicidal

danger. Sedation is an important adjunct in treatment, but the patient should not be treated at home with sedatives for extended periods because this may only add the complication of a toxic delirium to his involutional depression. As noted earlier in this paper, estrogen therapy has no place in the treatment of involutional psychoses. Until about eight years ago, there were reports of the use of estrogens in this illness, with somewhat equivocal results. Burlingame and Patterson<sup>1</sup> reported 59% remissions with forty days' treatment in 1941. Danziger<sup>2</sup> in 1942 reviewed the literature and found an average of 48% recovery in a large series treated with various estrogenic substances. He added 7 cases of his own, treated with diethyl stilbestrol, but admitted as a result of his study that such treatment was not specific.

Davidoff and Goodstone<sup>3</sup> in 1942 reported the use of testosterone propionate in the treatment of male patients with this illness, and found that 65% of their series of 20 cases responded well, while in a control group only 46% improved markedly. They attempted to segregate cases into mild, moderately severe, and severe, and found that severe cases did not respond well. They suggested psychogenic or organic causes for these cases rather than endocrine.

Davidoff, Reifenstein, and Goodstone<sup>4</sup> in 1943 reported 60% improvement in 45 female cases treated with diethyl stilbestrol, while there was similar improvement in only 42% in a control group of 128 cases.

In 1944, however, Bennett and Wilbur<sup>5</sup> refuted the usefulness of estrogens in the involutional psychoses, reporting 75 consecutive cases previously treated with estrogens without benefit. Using a combination of electroshock and psychotherapy they were able to report 91% of these patients either fully or socially recovered. They pointed out the great shortening in the average length of hospital stay for this condition in the previous several years and credited this to the advent of electroshock treatment.

The marked superiority of electroshock over other forms of treatment has been supported in later writings. Karnosh and Zucker<sup>6</sup> in 1945

<sup>1</sup> Burlingame, C. C., and Patterson, M. B.: Estrogen Therapy in the Psychoses, *J. Nerv. & Ment. Dis.* 94:265 (Sept.) 1941.  
<sup>2</sup> Danziger, I.: Estrogen Treatment of Agitated Depressions Associated with the Menopause, *Arch. Neurol. & Psychiat.* 47:305 (Feb.) 1942.  
<sup>3</sup> Davidoff, E., and Goodstone, G. L.: Use of Testosterone Propionate in Treatment of Involutional Psychosis in the Male, *Arch. Neurol. & Psychiat.* 48:811 (Nov.) 1942.  
<sup>4</sup> Davidoff, E., Reifenstein, E. C., and Goodstone, G. L.: The Treatment of Involutional Psychoses with Diethyl Stilbestrol, *Am. J. Psychiat.* 99:557 (Jan.) 1943.  
<sup>5</sup> Bennett, A. E., and Wilbur, C. B.: Convulsive Shock Therapy in Involutional States after Complete Failure with Previous Estrogenic Therapy, *Am. J. M. Sc.* 208:170 (Aug.) 1944.  
<sup>6</sup> Karnosh, L. J., and Zucker, E. M.: Handbook of Psychiatry, St. Louis, C. V. Mosby Co., 1945, p. 91.



estimated 80% of patients with involutional melancholia markedly improve with electroshock, showing a favorable response after five or six treatments. Huston and Locher<sup>7</sup> in 1948 found improvement in 75-85% in a group of 61 patients treated with electroshock while only 46% of a control group of 93 patients improved.

Conversely, studies utilizing estrogenic substances have entirely disappeared from the literature since 1944. Ward and Hamilton<sup>8</sup> in 1948 reported that in 100 cases of involutional psychosis, estrogen therapy was judged indicated because of neurocirculatory symptoms in only 19 cases, and of these only 4 were observed to have any beneficial effect.

The most specific treatment for involutional psychosis known today is electroshock therapy. Most present day authors consider an involutional depression the primary indication for electroshock. A series of ten to twelve convulsive treatments will usually gain sufficient improvement so that the patient can be discharged from the hospital free of his pressing complaints. In addition, psychotherapy, occupational therapy, the use of sedative tubs, maintenance of nutrition, fluid balance, and hydration are important factors.

#### Material Studied

In the twenty-six months between January, 1949, and March, 1950, we have had 58 admissions for involutional psychoses at the Queen's Hospital in Honolulu. Of these, 20 were committed to the Territorial Hospital without treatment, because of poor finances, poor placement and supervision in the convalescent period, or because their physical condition contraindicated immediate active therapy. One patient left the hospital against medical advice, leaving a series of 37 cases treated with electroshock. Fifteen of these were judged to be cases of involutional melancholia, 6 were involutional paranoids, and 16 were of the mixed type. Of the 37, 5 were later sent to the Territorial Hospital because of failure to respond to short-term treatment, or because of recurrence of the illness and financial inability to continue treatment on a private basis. Three others were each rehospitalized one time under our care

and are doing well now, to the best of our knowledge. Twenty-nine others recovered or were much improved with a single course of short-term treatment so that a total of 32 of the 37 patients (86.5%) are now functioning in the community with only short-term treatment. It should be remembered that these figures include a number of mixed and paranoid cases, whose prognosis is generally considered much less favorable than that of melancholia.

#### Results

The length of hospitalization varied from nine to forty-six days, with the average hospitalization twenty-four days. Patients were treated with a minimum of 4 electroshock treatments and a maximum of 30, with 12 the average number of treatments during hospitalization. In addition, these patients were followed with a variable number of outpatient treatments following their discharge. However, all were well enough to leave the hospital after the number of treatments cited.

Despite the fact that these patients were in the middle-age group with a higher incidence of physical ailments, there were no fatalities incurred by treatment; the only complication noted in the entire series was a single compression fracture of the thoracic spine. A number of these patients had hypertensive cardiovascular disease, and two had previously suffered cerebrovascular accidents with resultant hemiplegiae. Earlier, as a precautionary measure, we had occasionally used small amounts of curare intravenously just prior to treatment. More recently we have frequently used a single dose of tolserol orally an hour before treatment, with good muscular relaxation.

In addition, all patients received superficial psychotherapy with attempts to ameliorate situational factors and to modify some of the highly rigid personality traits. In selected cases, patients were also followed with deep psychotherapy.

#### Conclusion

It is obvious from the foregoing figures that involutional psychoses, although appalling in the acute phase, have an excellent prognosis when properly treated. Today no more effective treatment than electro-convulsive therapy is known for this illness.

<sup>7</sup> Huston, P. E., and Locher, L. M.: Involutional Psychosis, Course When Untreated and When Treated with Electroshock, *Arch. Neurol. & Psychiat.* 59:385 (March) 1948.

<sup>8</sup> Hamilton, D. M., and Ward, G.: The Hospital Treatment of Involutional Psychoses, *Am. J. Psychiat.* 104:801 (June) 1948.

The cases reported herein were treated by the staff of R. D. Kepner, M.D., of which the author is a member.  
Young Hotel Building.

# Hawaii

## MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D. Editor  
MRS. EDITH C. BENNETT Managing Editor  
WILLIAM JOHN HOLMES, M.D. News Editor  
HASTINGS H. WALKER, M.D. Advisory Board  
HOMER IZUMI, M.D. Advisory Board  
PETE OKUMOTO, M.D. Associate Editor, Hawaii  
EDWARD S. KUSHI, M.D. Associate Editor, Kauai  
C. H. ISHII, M.D. Associate Editor, Maui

### [ EDITORIALS ]

#### A.M.A. RESIGNATIONS

Eighteen of the 389 active dues-paying members of the Hawaii Territorial Medical Association have declined, for various reasons, to pay their 1950 dues to the American Medical Association, and are therefore to be dropped from the rolls of the A.M.A. on January 1, 1952, at which time their two years' grace will have expired. Their membership in the Territorial Association and in their County Societies will not be cancelled by this, as it would be in some States. Neither will their hospital staff status suffer, as it would in some Mainland hospitals.

Just what they will lose by this is not altogether clear. Presumably they will lose the right to attend A.M.A. meetings, except as a guest; certainly they will lose the right to read or discuss scientific papers before the A.M.A.'s Scientific Assembly. They will be unable to act as Territorial Delegate to the A.M.A., and, perhaps—as delegates to the Territorial Medical Association—to help elect him. It may be that the latter incapacity legally disqualifies them to act as—perhaps even to vote for—delegates from their County Societies to the Territorial Association.

Nearly all Specialty Boards require A.M.A. membership of their candidates, but it seems most unlikely that any of them would "unfrock" a Diplomate for loss of such membership.

What else do they lose? Well, they lose the privilege of supporting financially, for the first time in their lives (since dues have never before been charged by the A.M.A.), a great many worthwhile enterprises conducted and financed by the A.M.A.—the nine Councils, including those on Food and Nutrition, Pharmacy and Chemistry, Medical Education and Hospitals, and others; the numerous useful standing Committees of the

House of Delegates and the Board of Trustees; and other enterprises which have contributed so much to the high standards of medical practice in the United States today.

They lose, too, the right to protest, as members, against whatever they may dislike or disapprove of in the A.M.A., and to press for its correction.

However, their action is a concrete demonstration that A.M.A. membership is optional, not compulsory; and this is as it should be. We don't think the recalcitrant 18 made a wise decision; we hope that many of them will reconsider it and reinstate themselves. But we respect the thoughtful ones among their number for doing what they thought was right, and we're glad they weren't prevented from making the decision according to the dictates of their own consciences.

#### STATE JOURNAL EDITORS' CONFERENCE

Thirty-eight state medical journals were represented by their editors, business managers, or both, at the national conference of state journals held at A.M.A. headquarters on November 12 and 13, 1951.

Sponsored and paid for (transportation and all) by the A.M.A., this was in no way an A.M.A. meeting. Mr. Alfred Jackson of the State Journal Advertising Bureau made the arrangements for it, and Dr. George F. Lull, A.M.A. Secretary, welcomed the participants; but from there on it was a conference conducted by and for the state medical journals. Not a word was said about helping the A.M.A. or even cooperating with it; indeed, it was a conference of the A.M.A. *Journal's* competitors!

The questions discussed covered such matters as the responsibility of the editor; financing and business methods; journal makeup; typographic styles and practices; advertising rates; costs of



publication; and many others. Talks by individual speakers were followed by panel discussions and periods for answering questions from the floor.

The relative lack of serious criticism of the A.M.A. by state journals has long been a source of annoyance and puzzlement to the A.M.A.'s more vocal critics, and some of them have suggested and even stated flatly that state journals are "muzzled" by the A.M.A. We have been informed by one such critic that these conferences of state journal editors are held largely for just this purpose—to tell the editors what to say and what not to say.

So far as this conference is concerned, we can say that this statement is just as utterly nonsensical as it sounds. This conference was a serious technical meeting at which numerous common problems were aired, with great benefit to most if not all of the participants. There wasn't a muzzle in sight! — H.L.A.

### **CATASTROPHIC HEALTH INSURANCE**

Several million Americans know very well that "full coverage" automobile collision insurance is far beyond their means; it is too costly for most of them even to consider. Most of them buy "deductible" policies for protection against serious, major accidents, and plan to pay for all the accidents up to costs of \$50 or \$100 out of their own pockets.

It is odd, in view of this, that hardly anyone seems to realize that "full coverage" health insurance—that is, a policy which takes care of illnesses costing only \$5, \$10, or \$20—is just as prohibitively expensive as the automobile policy would be. It seems probable—on a rough guess—that the "overhead" costs of processing a \$3.50 or \$5.00 claim might run as high as 100 per cent of the claim. And who *wants* such a claim covered? Certainly anyone who can afford to pay health insurance premiums at all can afford to handle items of this size out of his own pocket. As our high-powered New York consultant of a few years back, Mr. Thompson, told us, they "don't have insurable value."

The Liberty Mutual Insurance Company of Boston now offers "disaster" insurance. A typical plan offered by them provides a maximum payment of \$5000 in a single case, and contains a \$300 deductible clause. After the patient has paid the first \$300, the company pays three-fourths of the remaining costs. The premium is \$2.25 monthly for one person, \$4.50 for a family, on a group basis—and slightly higher for individual customers. Other companies are expected to offer comparable policies in the near future; Conti-

mental Casualty and Lloyd's are already writing some similar to the above.

We cannot afford complacency about our present voluntary healthy insurance plans. They have defects, of which this concern with small claims is one of the more serious. Our experience with car collision insurance shows us the way—let's follow it!

### **MEMBERS MAY "SUSPEND" ASSOCIATION GROUP INSURANCE WHILE SERVING WITH ARMED FORCES**

Members of the Hawaii Territorial Medical Association who enter the military or naval service should place their Association Group Accident and Health Insurance in "suspense" during the period of their service. This is the advice of Mitchell Hutchinson, C.L.U., of Brainard and Black, Ltd., administrators of the Society's Plan.

Under a recent ruling of the United States Life Insurance Company, underwriters of the Group Plan of the Hawaii Territorial Medical Association, a doctor may discontinue his disability insurance upon entering the armed forces and resume it upon his return to civilian practice on the following bases:

1. Upon entering the service, the doctor can surrender his policy and the premium which has been paid for the current period will be prorated and a refund made for any unused period of coverage.
2. When discharged from military or naval service, the doctor may reinstate his policy, provided written application is made within 60 days from the date of discharge and he is regularly attending all of the duties of his occupation on the date of application.

When the policy is reinstated, there will be no back premiums or arrears to pay. Only the normal premium charge for the subsequent period is payable.

This provision is important since members have hesitated to discontinue their insurance under the Plan for any reason. The Plan sponsored by the Association contains many features not otherwise available to doctors and is lower in cost than Disability Insurance obtained upon an individual basis. Normally, if a member should discontinue or allow his policy to lapse, it is necessary that evidence of good health be presented before a new policy can be obtained or the old one placed in force again. The new reinstatement privilege provides a method for members entering the military service to merely "suspend" their protection and cease paying premiums for the period of such service. Upon returning to civilian practice and by meeting the conditions outlined above, they can be assured that they can resume this valuable protection.

# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## DELEGATE'S REPORT OF CLINICAL SESSION

(December 4-7, 1951, Los Angeles)

Your delegate saddled up and rode across the prairie to the Painted Desert on Monday night, December 3. That same evening the Los Angeles County Medical Society were hosts to the House of Delegates at a banquet called "A Night in Hawaii." This was evidently a huge success as everyone seemed to enjoy it. The menu was printed in Hawaiian and I was called upon to translate it, so it is a good thing I did not arrive until the next morning.

On Tuesday, December 4, the House of Delegates convened at the Biltmore Hotel. I was a substitute appointee for the committee on Executive Session, but fortunately no matters of business were referred to the committee, so we held no meeting.

Dr. Cline gave an excellent address in his usual forthright and capable manner. He stressed: (1) aid to the Medical Education Foundation. He pointed out that individual contributions by doctors in the United States have been too infrequent and too small. He noted that all of us paid for our medical education less than it cost the medical schools, and at this time, when a foundation has been set up to aid medical education, we should all contribute. He emphasized that in each State, Territorial and County Society there should be committees appointed to raise funds for this purpose in order to forestall Government financing of medical schools. (2) He said, "Never again must we be on the defensive against the Socializers." (3) He stated that the Woman's Auxiliary in each community should receive a great deal of encouragement as 1952 is an important year and that the Auxiliary could be of great help.

Dr. Dwight Murray (California), Chairman of the Board of Trustees, noted that the Board of Trustees had again contributed \$500,000 to the Medical Education Foundation and he again deplored the small contribution by individual physicians in their own communities to this Foundation.

The Judicial Council Report was made by Dr. Cunniff of New York, who listed the meetings and the work of the Council. He stated it was ethical, in the opinion of the Judicial Council, for physicians to accept payment from insurance policies carried by physicians or their dependents.

The "family doctor of the year" was then chosen by ballot from three names submitted—Dr. A. C. Yoder, of Indiana, age 84, received this honor.

Mr. Don Wilson, National Commander of the American Legion, told the House the Legion was opposed to socialized medicine.

Tuesday afternoon was devoted to the introduction of resolutions to the House of Delegates.

Wednesday, December 5, I breakfasted with Dr. and Mrs. Robert Benson and Dr. Charles Wilbar. I then attended the session of the committee on Insurance and Medical Service under the Chairmanship of Dr. Raymond McKeown, of Oregon. Progress in the study of physicians' placement was discussed as well as the fact that there appeared to be no need for the revival of the

E.M.I.C. Program, as voluntary insurance policies should cover these individuals. The hospitality of the Illinois and California delegations was enjoyed on Wednesday at noon. During the afternoon, thanks to a gift from the Hawaii Visitors Bureau, I distributed orchid leis to the rooms of the officials and officers of the American Medical Association. That evening the Pennsylvania delegation entertained the House prior to boarding buses to the Shrine auditorium where a most impressive meeting was held. The auditorium was packed with 7,000 persons and there were 5,000 outside trying to get in. This was a meeting of the House of Delegates which was addressed by Senator Robert Taft, of Ohio, and Senator Harry Byrd, of Virginia. This was broadcast coast-to-coast, and televised on the west coast.

Thursday, December 6, I had a chance to view the scientific exhibits and enjoyed talking with Dr. Robert Glover, of Pennsylvania, regarding his surgical treatment of mitral stenosis, which is quite evidently gaining popularity in various parts of the United States. I saw an excellent exhibit instructing doctors how to avoid malpractice suits by avoiding careless remarks. Another exhibit which attracted my attention was one by Drs. Lichstein and Asher, of Los Angeles, on the subject of prolapse of the gastric mucosa.

Thursday morning there was the final session of the House of Delegates. Six matters which transpired should be mentioned: (1) the House approved the adding of fluoride to water in any community for the purpose of preventing dental caries; (2) the report of the Committee on Blood Banks was accepted. Twenty-six states and Hawaii have blood collecting programs which were heartily approved by the committee. (3) The magazine, "Today's Health" edited by Dr. W. W. Bauer, should be subscribed to by every physician and should be in their offices. It was felt that if every physician in the United States subscribed to this excellent little magazine, its financial difficulties would largely disappear. (4) It was decided to purchase some land in Washington, D. C. for the purpose of maintaining a local office of the American Medical Association there. (5) Once again, the "Hess" report (named for Dr. Elmer Hess, of Pennsylvania, who introduced it) was discussed. Having obtained considerable legal advice, the House decided that any decision regarding the compensation of pathologists, anesthetists, and roentgenologists in hospitals should be decided at the local level. However, a ladder of procedure was established so that if either a hospital or a physician should be dissatisfied with the local arrangement, appeals could be carried to the Judicial Council for final decision. (6) It was pointed out that any one of the numerous specialty journals published by the American Medical Association could be substituted for the Journal of the A.M.A., and that this courtesy was extended to all members.

Your delegate is grateful to Dr. Charles Wilbar who attended a two-day session on the subject of Public Relations prior to December 4.

ALFRED S. HARTWELL, M.D.

*Delegate, Territorial Medical Ass'n*



## REPORT ON ANNUAL MEDICAL PUBLIC RELATIONS CONFERENCE OF THE AMERICAN MEDICAL ASSOCIATION

**Held December 4-7, 1951, in  
Los Angeles, California**

The pre-session meeting of the Annual Medical Public Relations Conference was held December 2 and 3, but I was not able to arrive in Los Angeles until the evening of December 2, so I attended only the December 3 sessions.

Dr. Harlan A. English of Danville, Illinois, of the Committee on Rural Medical Services of the Illinois State Medical Society, stated that most patients ask three things of the doctor: 1) What is the trouble? 2) How long will it take to get over it? 3) What will it cost? He stated that the good practitioner informs the patient the rates of his fees and most patients ask what his fees are. He said that it is always a good rule for a doctor not to under-cut or greatly exceed the going fee schedule of the community.

Dr. Cyrus W. Anderson of Denver, Colorado, chairman of the Board of Trustees of the Colorado Medical Society, said that the doctor must explain to the patients the extra costs which are present on the hospital bill. Dr. Anderson thought that there are too many laboratory tests done because the use of laboratory tests has been advertised too much in medical schools. He advised medical societies to hire the best public relations people they can afford in order to tell you how patients see you (practicing doctors collectively). He said the Colorado Medical Society has an annual press, radio and medical dinner merely for conviviality and to attempt to bring about a cordial understanding between the doctors and the newsmen.

Dr. Stanley R. Truman of Ventura, California, Past-President of the American Academy of General Practice, stated that there is a great deal of resentment among patients against waiting in doctors' offices. A certain amount of waiting cannot be prevented, but the important matter is the way the patient is handled during the waiting period, particularly by the secretary or nurse. He mentioned that the Ohio State Medical Association has published a six-leaf pamphlet entitled "A Date With The Doctor," which he feels is an excellent one on the subject of public relations in the doctor's office.

Mr. Stanley Mauck of Columbus, Ohio, Executive Secretary of the Columbus Academy of Medicine, said that the most important factor in public relations of bill collecting is the handling of the matter by the doctor and his office staff, not by a bill-collecting agency.

Dr. Earl W. Mericle of Indianapolis, Indiana, chairman of the Indiana State Medical Association, talked on the subject "Your Patient and His Big Bills." He said the real need is for an insurance plan for cases not eligible for group insurance. Part of the trouble is lack of hospital beds for degenerative illnesses. He men-

tioned that the California Physicians' Service was trying out a plan on Catastrophic Health Protection. They charge \$.90 per month for a man and \$1.15 per month for a woman. Also, two insurance companies have begun to write deductible catastrophic insurance.

Mr. Joseph F. Donovan of San Jose, California, Executive Secretary of the Santa Clara Medical Society, said that his county had followed the lead of certain other California counties and that the medical society had advertised that all persons in the county would get adequate medical care regardless of their ability to pay. They ran ads in the newspapers and have received only 59 calls in six months for free medical care in response to their ads. These calls are distributed among the 300 doctors of the county. Mr. Donovan believes this is the best plank in the public relations program of the county medical society.

Dr. Willis H. Huron of Iron Mountain, Michigan, Past Counselor of the Michigan State Medical Society, stated that the Michigan Medical Society had started the medical health council and continued to keep in close touch with it. The Council issues a yearly directory of health agencies and has started 40 local health councils in the State of Michigan. The state commissioner of health is invited to every meeting of the Executive Board. The medical society of Michigan actively participates in 80 different state health organizations, private and governmental. The Woman's Auxiliary of the Michigan Medical Society is 25 years old and greatly aids in the public relations program.

Mr. Leo E. Brown, Director of Public Relations of the American Medical Association, stated the objectives of his organization for 1952 are:

- a) Strengthen American Medical Association by getting people to know it;
- b) Get state societies to work closely with the American Medical Association;
- c) Improve patient-physician relationship by emphasizing services;
- d) Encourage state and local societies to improve and expand public relations program.

A number of brochures will be printed and distributed by the American Medical Association for the above purposes. Leaders of national organizations of all kinds are being invited to visit the AMA central office.

Dr. Joseph E. Mott of Paterson, New Jersey, of the Sub-Committee on Public Relations of the Medical Society of New Jersey, stressed that it is necessary to have an adequate budget to have a good public relations program on the state level. He said that competent paid workers are needed to do a good job. His committee has encouraged county public relations committees to invite the chairman of the Woman's Auxiliary to be present at their meetings. Like Colorado, New Jersey has an annual press-radio-medical get-together. He said that health councils are a good way to find out what the public thinks about the doctors.

C. L. WILBAR, JR., M.D.

**SUPPLEMENT TO HAWAII MEDICAL JOURNAL**  
**JANUARY-FEBRUARY, 1952**

DOCTOR: For a constant reminder of medical meetings in the year  
1952, place this where you and your secretary can see it.

**HOSPITALS**

**Children's**

Monday—12:30 P.M.—weekly  
Luncheon—case reports  
Friday—12:30 P.M.—monthly staff luncheon and  
meeting—4th Friday

**Kapiolani**

Tuesday—4:00 P.M.—weekly  
Ob. and gyn. pathology seminar under  
Dr. C. Moran (open to all M.D.'s)  
Thursday—12:30 P.M.—monthly staff  
3rd Thursday

**Kuakini**

Friday—5:15 P.M.—monthly  
Dinner and staff meeting  
2nd Friday

**Leahi**

Friday—7:30 P.M.—Sinclair Club  
(For study of chest diseases)  
2nd Friday—monthly

**Queen's**

Thursday—12:30 P.M.—monthly  
Staff meeting and luncheon  
Last Thursday

**St. Francis**

Friday—12:30 P.M.—monthly  
Staff meeting and luncheon  
3rd Friday  
Pathology Conference (Dr. C. Moran)  
same time 2nd and 4th Friday

**TUMOR CLINICS**

**Kuakini Hospital**—monthly

2nd Wednesday—1:00 P.M.  
Call Dr. Tilden, phone 5-0901, to schedule cases.

**Queen's Hospital**—bi-weekly

1st and 3rd Tuesday—12:45 P.M.

**St. Francis Hospital**—monthly

1st Friday—12:45 P.M. in O.P.D.  
Call Dr. Quisenberry, phone 5-0511, Ext. 220, to  
schedule cases.  
For Home Nursing Cancer Service, call Dr. Quisenberry at above number.  
For Cancer Cytologic Diagnostic Service, call  
5-2323 or 5-2807 for details.

**SOCIETIES**

**Honolulu County Medical Society**

Monthly meeting—1st Friday—7:30 P.M.  
Board of Governors—Tuesday of week preceding  
above—4:15 P.M.

**Honolulu Academy of General Practice**

2nd Monday—monthly—7:30 P.M.  
Pres.—Dr. A. L. Vasconcellos  
Vice Pres.—Dr. John M. Felix  
Sec.-Treas.—Dr. Robert F. Bailey

**Hawaii Dermatological Society**

Meets at announced dates  
Pres.—Dr. Harold M. Johnson  
Sec.-Treas.—Dr. Harry L. Arnold, Jr.

**Honolulu Eye, Ear, Nose & Throat Society**

3rd Thursday—monthly  
Pres.—Dr. C. W. Trexler  
Sec.-Treas.—Dr. John Frazer

**Honolulu Obstetrical & Gynecological Society**

3rd Monday—monthly—7:30 P.M.  
Pres.—Dr. Herbert E. Bowles  
Sec.-Treas.—Dr. James T. S. Wong

**Honolulu Orthopedic Society**

1st Thursday—monthly—7:30 P.M.  
Pres.—Dr. J. Warren White  
Sec.-Treas.—Dr. John W. Cooper

**Honolulu Pediatrics Society**

3rd Thursday—monthly (closed)  
Pres.—Dr. Teruo Yoshina  
Sec.-Treas.—Dr. John H. Peyton

**Honolulu Surgical Society**

3rd Friday—alternate months (Jan., Mar., May,  
etc.)—7:30 P.M.  
Pres.—Dr. Laurence M. Wiig  
Sec.-Treas.—Dr. Lester Yee

**Hawaii Territorial Medical Association**

May 1 to 4, 1952  
Meets in Honolulu

**Territorial Ass'n of Plantation Physicians**

Meets November, 1952  
Pres.—Dr. Clarence L. Carter, Honokaa, Hawaii  
Sec.-Treas.—Dr. Garton E. Wall, Ewa

*Compliments of*



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6044  
6-8865

THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONE  
7-8411





## MEDICAL NEWS

---

It Was Inevitable: that someone should report cure of **Bell's palsy** with **cortisone**. Someone has. (Rathendler, *J. Nervous & Mental Dis.* 114:346 [Oct.] 1951.) The rationale, nonspecific anti-inflammatory action of cortisone, actually sounds rational, and it may well be worth trying in early cases to avert permanent palsy.

**Frozen human red cells** have been reported to have a normal survival time in transfusion recipients, by Mallison and Slaviter (*Lancet* 2:862 [Nov. 10] 1951). The cells are frozen at 79° C. in 30% glycerol and 70% normal saline solution. Before use the glycerol must be washed away (dialysis), and the cells resuspended. Somewhat cumbersome, but the method may prove vital in stockpiling blood for atomic disaster.

**Desoxycorticosterone acetate (DOCA)** proved extremely valuable as an adjunct in intravenous fluid therapy of ten malnourished and dehydrated children, according to Bigler and Traisman (Children's Memorial Hospital, Chicago) (*Am. J. Dis. Child.* 82:548 [Nov.] 1951). Salt and fluid retention with prompt weight gain (the expected results), were followed by cessation of vomiting and diarrhea, return of appetite, and continued uphill course—welcome dividends.

Addendum to already huge armamentarium: **podophyllotoxin** in 3% solution, applied daily for thirty days, cured 9 of 14 patients with **tinea capitis**, and deserves further study, says C. Jack Young (Univ. Virginia) (*Arch. Dermat. and Syph.* 64:607 [Nov.] 1951).

Reports on **intravenous saccharated iron oxide** continue to be favorable. Developed in

England, this product has been on the American market for over a year. Holly (Univ. Minnesota) reports good results in 21 of 23 pregnant women with iron deficiency anemia (*Blood*, 6:1159 [Nov.] 1951). He regards intravenous iron as particularly useful in these patients because it enables a rapid build-up of hemoglobin level in the limited time before delivery. The danger of inducing hemochromatosis makes it imperative to avoid prolonged or repeated courses.

**Para-aminosalicylic acid** can be administered **subcutaneously** (2 per cent solution) with the use of **hyaluronidase**, as demonstrated by Fisher, Roberts and Hinshaw (*Am. Rev. Tuberc.* 64:557 [Nov.] 1951). This should prove a useful stunt in patients who exhibit gastrointestinal upsets with oral administration of PAS.

In an editorial (*Arch. Surg.* 63:585) Hinman recommends the use of **hyaluronidase** (150 units) with the subcutaneous injection of **diodrast** (10 cc. of 35% diodrast diluted to 50 cc.), to speed up absorption and obtain sharper excretory urograms in infants, where intravenous injection of the dye is next to impossible.

**Vitamin B<sub>12</sub>** is reported to be of considerable value in **diabetic neuropathy**, by Sancetta, et al. (*Ann. Int. Med.* 35:1028 [Nov.] 1951). They emphasize the need for frequent doses rather than massive doses. Experience has been the same at the Mayo Clinic: massive doses (up to 6000 gamma daily) were of no value in various types of neuritis (with the exception of neurologic changes accompanying pernicious anemia).

C. A. DOMZALSKI, M.D.



# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*  
MRS. MARTHA WEBER, *Assistant Librarian*  
Phone 65370  
8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.  
Monday through Friday  
Closed Saturdays at noon and Sundays  
Closed all day and evening on National holidays  
and at noon on Territorial holidays

## RECENT ACQUISITIONS

### Anatomy

Dickinson, R. L. *Human sex anatomy*. 2nd ed. c1949.  
(from the Board of Medical Examiners)

### Dietetics

Johnson, Doris. *Modern dietetics*. c1951. (gift of publisher)

Nasset, E. S. *Food and you*. c1951. (gift of publisher)

### Endocrinology

Albright, Fuller. *The parathyroid glands and metabolic bone disease*. c1951. (gift of publisher)

Fleischmann, Walter. *Comparative physiology of the thyroid and parathyroid glands*. c1951. (gift of publisher)

Heckel, N. J. *The effect of hormones upon the testes and accessory sex organs*. c1951. (gift of publisher)

Kountz, W. B. *Thyroid function and its possible role in vascular degeneration*. c1951. (gift of publisher)

McGavack, T. H. *The thyroid*. c1951. (gift of publisher)

### Eye, Ear, Nose and Throat

Fabricant, N. D. *Modern medication of the ear, nose and throat*. c1951. (gift of publisher)

Lancaster, J. E. *A manual of orthoptics*. c1951. (gift of publisher)

### Genito-Urinary System

Smith, H. W. *The kidney*. c1951. (gift of publisher)

### Gynecology

Randall, L. M. *Amenorrhea*. c1951. (gift of publisher)

### Hematology

Pollak, O. J. *Grouping, typing and banking of blood*. c1951. (gift of publisher)

### Laboratory Technic and Pharmacology

Kolmer, J. A. *Approved laboratory technic*. 5th ed. c1951. (gift of publisher)

Marsh, D. F. *Outline of fundamental pharmacology*. c1951. (gift of publisher)

### Neurology and Psychiatry

Bailey, Percival. *The isocortex of man*. c1951. (from the University of Illinois)

Ecker, Arthur. *The normal cerebral angiogram*. c1951. (gift of publisher)

Kuntz, Albert. *Visceral innervation and its relation to personality*. c1951. (gift of publisher)

Penfield, Wilder. *Epileptic seizure patterns*. c1951. (gift of publisher)

Pool, J. L. *The neurosurgical treatment of traumatic paraplegia*. c1951. (gift of publisher)

Sullivan, A. J. *Personality in peptic ulcer*. c1950. (gift of publisher)

### Orthopedics

Bancroft, F. W., ed. *Surgical treatment of the motor-skeletal system*. 2nd ed. In 2 vols. c1951. (from the Board of Medical Examiners)

Hass, Julius. *Congenital dislocation of the hip*. c1951. (gift of publisher)

### Poliomyelitis

Fishbein, Morris, ed. *A bibliography of infantile paralysis. (1789-1949)* 2nd ed. c1951. (from the National Foundation for Infantile Paralysis)

### Roentgenology

Steel, David. *Roentgen anatomy*. c1951. (gift of publisher)

Weyl, Charles. *Radiologic physics*. 2nd ed. c1951. (gift of publisher)

### Surgery

Elman, Robert. *Surgical care*. c1951. (gift of publisher)

### Miscellaneous

Marie, J. S. F. *English, German, French, Italian, Spanish medical vocabulary and phrases*. c1939. (gift of the U. of Hawaii)

Reveno, W. S. *711 medical maxims*. c1951. (gift of publisher)

*Studies in medicine: a volume of papers in honor of Robert Wood Keeton*. c1951. (gift of publisher)

Williams, Harley. *The healing touch*. c1951. (gift of publisher)

Through our membership in the Medical Library Association, we have received many issues of medical journals to help complete our files. Since the Association has expanded its membership to include foreign libraries, packages have been arriving from some of the following places: The Academy of Medicine in Toronto, the Royal Society of Medicine and the Royal College of Surgeons in London, the Instituto Adolfo Lutz and the Instituto Butantan in Brazil, and the World Health Organization in Geneva.

Among the new medical journals being published in Japan which are of interest, we wish to call your attention to the following: The Medical Journal of Osaka University, The Journal of Mie Medical College, and the Yokohama Medical Bulletin.

# BOOK REVIEWS

---

## **711 Medical Maxims.**

By William S. Reveno, M.D., 197 pp. Price \$3.75.  
Charles C. Thomas, 1951.

This book is as much fun to read as a Who-Done-It. Any physician who reads it will within the first few pages learn something of interest or at least be reminded of something that he had long since forgotten. All of the remarks are extremely brief and to the point and comprise in each case only one single isolated observation. As Dr. Kerr says, one is likely to remember these brief aphorisms when two or three paragraphs taken to make the same statement would be forgotten. All dogmatic statements are of course to be taken as the rule, to which exceptions are usually to be found.

I recommend the book highly. It is a brief and pleasant postgraduate course in several fields of medicine.

H. L. ARNOLD, M.D.

## **Amenorrhea.**

By Lawrence M. Randall, M.D., and Thomas W. McElin, M.D., 74 pp. Price \$2.25. Charles C. Thomas, 1951.

The subject matter in this monograph is presented by an extensive review of the literature. There is but little editorial comment. The reader is left to "wade" thru the abstracts of current comment and opinion. This I don't think many busy practitioners will be inclined to do.

It seems that thyroid is still the most universally accepted drug for the amelioration of functional amenorrhea. Beyond that most every one has his own "pet" form of cyclic therapy with a wide choice of endocrine products being offered by the pharmaceutical houses.

FRANK C. SPENCER, M.D.

## **Modern Medication of the Ear, Nose and Throat.**

By Noah D. Fabricant, M.D., M.S., 245 pp. Price \$5.75.  
Grune & Stratton, Inc., 1951.

The author has condensed into this volume the principles which support the proper manner in which to treat ear, nose and throat diseases. This is a sound and rational presentation with discussion of the most recent therapeutic methods as well as time-tested medications. The treatment of many diseases formerly dependent largely on surgical intervention for cure has been modified by the discovery of modern chemotherapy. "Some who have not kept themselves properly informed fail to realize that drugs alone cannot cure all patients of their various ailments." Much of the resultant confusion, whether a patient needs surgery or to be treated medically, has been cleared up by the author in his careful appraisal of modern medication.

There is much to be gained from this well written book, which is supplemented by a sufficient list of contemporary references.

TADAO HATA, M.D.

## **Atlas of Genito-Urinary Surgery.**

By Philip R. Roen, M.D., F.A.C.S., 325 pp. with illustrations. Price \$8.00. Appleton-Century-Crofts, Inc., 1951.

When it comes to explaining an operative procedure, one good drawing is worth more than many words of explanation. This is well exemplified in this Atlas, which clearly and decisively illustrates the surgical correction of 71 genito-urinary disorders. The illustrations are excellent and accompanied by brief but clear captions.

It is not only an excellent reference work for the medical student, intern and resident, but it affords easy reference for the more experienced general surgeon and even urologist who may wish to quickly review some special technique just previous to its execution. While a number of well recognized methods of surgical correction of the lesions discussed are not included and could not be in an Atlas of this size, the ones that are presented represent good surgical practice.

A word of warning regarding the method of ligation of the vas deferens. This method no doubt suffices for the prevention of epididymitis accompanying surgery of the genito-urinary organs. In my hands, however, it has not been a dependable method of sterilization. If both ends of the vas are left in the same fascial sheath, there is likelihood of re-establishment of its lumen, as has occurred in my hands, much to my chagrin.

Everyone interested in the problems of general surgery and particularly urological surgery should have this Atlas on his book shelf.

J. E. STRODE, M.D.

## **The Thyroid.**

By Thomas Hodge McGavack, B.A., M.D., F.A.C.P., 646 pp. with illustrations. Price \$13.50. The C. V. Mosby Company, 1951.

This thorough treatise on the thyroid gland is written from the viewpoint of the internist. The surgical section consists merely of the last thirty pages and is quite sketchy. Discussions of the history of thyroid disorders, of the anatomy, biochemistry and physiology of the gland and of the various morbid states are complete. I was particularly impressed by the chapter covering the biochemistry of the thyroid hormone and the interrelationship between the thyroid gland and other glands of internal secretion. The discussions of the extra thyroidal factors which influence the function of the thyroid follicle and of the complex thyrotropin—thyroid hormone—iodide balance are especially good. There is also a complete discussion of the status of radioisotopes in thyroid disease (subject to even more recent studies on the subject).

The book is a very worthwhile one which brings into one volume all but the most recent advances in the study and treatment of thyroid disorders.

G. C. FREEMAN, M.D.



### **Roentgen Anatomy.**

By David Steel, M.D., 109 pp. with 108 full page plates. Price \$8.00. Charles C. Thomas, 1951.

This is the only book of its type and as such fills a definite need. It would be of extreme value to medical students, trainees in radiology and those who do not interpret x-rays frequently. It is a handy reference to any practicing physician. The reproductions of the x-rays are uniformly good with the exception of the detail in a few of the skull films. With the exception of the chest, the entire volume is devoted to the skeletal system. All soft tissue examinations such as a plain abdomen, the genito-urinary, the gastro-intestinal tract and all more specialized examinations such as myelograms, salpingograms and encephalograms, are omitted.

PHILIP S. ARTHUR, M.D.

### **Food and You.**

By Edmund Sigurd Nasset, Ph.D., 92 pp. Price \$3.00. Charles C. Thomas, 1951.

For an excellent review on the digestion of foods, and the utilization of proteins, fats, carbohydrates, vitamins, and the mineral elements, this monograph answers the purpose.

Dr. Nasset has an interesting section on how to use the facts of nutrition to advantage in the selections and preparation of food.

This book would be most suitable for persons interested in a review of composition and digestion of foods and is discussed in an easy-to-understand language for the layman.

RUTH TORESON

### **Grouping, Typing and Banking of Blood.**

By Otaker Jaroslav Pollak, M.D., Ph.D., 184 pp. with 27 illustrations. Price \$5.75. Charles C. Thomas, 1951.

In the preface, the author states that "This is a simple book." It is just that, as it is readable, informative and illustrates complex problems in such a manner to make them easily understood.

The book is written for the laboratory technician, for the intern and resident, and for the practicing physician who does not have the time to plow through elaborate tomes on immunohematology, blood groups and blood banking. These subjects are all covered in plain everyday language, without diversion into byways of interest only to the expert. It fills a need which has been apparent for a long time.

Your reviewer heartily recommends this short book to all who may have questions concerning blood banking and its attendant problems.

LEON E. MERMOD, M.D.

### **The Effects of Hormones Upon the Testis and Accessory Sex Organs.**

By Norris J. Heckel, A.B., M.D., 73 pp. Price \$2.25. Charles C. Thomas, 1951.

Altho this book has but 55 pages it is packed with information. Detailed descriptions are replaced by photographs illustrating the results of treatment. The known therapeutic uses of the estrogens and androgens are recorded. The newer concepts of the effects of androgen therapy on spermatogenesis are explained. For me, the pernicious practice of abbreviating the names of the hormones made part of the book less interesting.

R. O. BROWN, M.D.

### **Approved Laboratory Technic.**

By John A. Kolmer, M.D., D.P.H., Sc.D., F.A.C.P., Earle H. Spaulding, Ph.D., and Howard W. Robinson, Ph.D., Fifth Edition, 1180 pp., 403 illustrations, 28 color plates. Price \$12.00. Appleton-Century-Crofts, Inc., 1951.

This book is the fifth edition of the volume previously written by Kolmer and Boerner. A number of the authoritative individuals have also participated in its production. This work remains as one of the best tomes for guidance in laboratory methodology. It gives very lucid descriptions of the acceptable procedures and utilizes the latest terminology. These above mentioned factors plus the arrangement and indexing of this work, makes it of practical value to those whose particular bent is directed along the lines of clinical pathology. It is not a book for one with only an occasional interest in the laboratory.

As far as purely physical factors of production are concerned, the book is well bound and not overly large, and the print is legible.

W. HAROLD CIVIN, M.D.

### **Congenital Dislocation of the Hip.**

By Julius Hass, M.D., 398 pp. with illustrations. Price \$12.50. Charles C. Thomas, 1951.

This condition, which affects females far more frequently than males, is often met with in the practice of orthopedics. This book is a very detailed and complete monograph on the subject.

Dr. Julius Hass, who was associated with Lorenz for many years, has had tremendous experience with this deformity. He has had a series of more than 2,000 cases. As in other phases of medicine, there is still difference of opinion concerning the treatment of congenital dislocated hips. Here the author attempts to appraise the more recent theories concerning the etiology and then presents the best methods of treatment. Dr. Hass himself is a great advocate of early diagnosis and closed reduction.

This book is well written and attractively bound, and the reproductions of radiographs are of high quality. It should have its greatest appeal to the orthopedic surgeon.

B. ALLEN RICHARDSON, M.D.

### **The Neurosurgical Treatment of Traumatic Paraplegia.**

By J. Lawrence Pool, M.D., 107 pp. Price \$3.00. Charles C. Thomas, Publisher, 1951.

Another of the American Lecture Series monographs, this little book adequately covers the material suggested by the title. The author had a wide experience in the field during the past war and has also written on various aspects of the problem.

The text is well illustrated with x-ray reproductions, sketches and photographs of types of traction. The pathologic physiology is elucidated and used as a guide for treatment.

Like all this series, the print is large and easy to read. The book represents a good summary of the problems and accepted methods of treatment.

JOHN J. LOWREY, M.D.

## **The Kidney—Structure and Function in Health and Disease.**

By Homer W. Smith, A.B., Sc.D., M.S., 1040 pp. with illustrations. Price \$12.50. Oxford University Press, 1951.

Dr. Homer Smith has presented a classic monograph of renal physiology which covers all phases of the subject in exhaustive and painstaking detail. It is primarily an advanced research dissertation, replete with experimental data and backed by a bibliography of 2300 references. This is probably the most comprehensive monograph on renal physiology in health and disease produced to date.

A. V. MOLYNEUX, M.D.

## **Untoward Reactions of Cortisone and ACTH.**

By Vincent J. Derbes, M.D., and Thomas E. Weiss, M.D., 77 pages. Price \$2.25. Charles C. Thomas, 1951.

Concise and up-to-the-minute, this little volume exemplifies the virtues of Thomas's American Lecture Series of monographs, of which it is Publication Number 131. The basic physiology of the hormones is reviewed, and reactions to them (rather than of them!) are discussed by body systems, with a chapter for each one headed by a summary.

Some corrections might be suggested for a second edition. The Wenckebach phenomenon is explained for the reader; "Sheehan's syndrome" is not, however, and the dictionary (Dorland's) does not define it. The oxygen atom at the 11-carbon position in the 11-oxysteroids is referred to repeatedly as an oxygen "molecule." The solecism in the title has been mentioned.

In general the book is well worth owning, however, as a ready reference work. Of the 96 references to the literature, 18 are to articles appearing in 1951. There is an index to most of the subjects and a few of the authors cited.

HARRY L. ARNOLD, JR., M.D.

## **The Normal Cerebral Angiogram.**

By Arthur Ecker, M.D., Ph.D. (Neurology), 190 pp. with illustrations. Price \$6.50. Charles C. Thomas, 1951.

This monograph is divided into two parts: Technic, and Angiographic Anatomy. In the first part the author gives clearly in detail his method of performing percutaneous carotid and vertebral angiography. A careful and useful listing of all necessary equipment and assistance is given. The directions are clear and concise, but I believe make the procedure sound rather simpler than many find it to be. The complications, and patients' discomfort, seem rather to be minimized.

Part II, Angiographic Anatomy, is very well done with many excellent figures. The author has had ex-

tensive experience with this subject and the book will be very useful to any specialist interested in performing angiography or interpreting the roentgenograms.

JOHN J. LOWREY, M.D.

## **ALSO RECEIVED**

### **Roentgen Manifestations of Pancreatic Disease.**

By Maxwell Herbert Poppel, M.D., 366 pp. with 166 illustrations. Price \$10.00, Charles C. Thomas, 1951.

### **Transactions of the International and Fourth American Congress on Obstetrics and Gynecology.**

Edited by George W. Kosmak, M.D., 823 pp. with illustrations. Price \$13.50, C. V. Mosby Co., 1951.

### **The Art of Administration.**

By Ordway Tead, 223 pp. Price \$3.75, McGraw-Hill Book Company, Inc., 1951.

### **Chronology of Ophthalmic Development.**

By Arthur H. Keeney, M.D., 32 pp. with 3 charts. Price \$2.00, Charles C. Thomas, 1951.

### **Proceedings of the International Society of Hematology.**

Edited by Carl V. Moore, M.D., 593 pp. Price \$10.00, Grune & Stratton, Inc., 1951.

### **Children from Seed to Soplings.**

By Martha May Reynolds, Second Edition, 334 pp. Price \$3.75, McGraw-Hill Book Company, 1951.

### **The Architecture of Normal and Malformed Hearts.**

By Maurice Lev, M.D., and Aloysius Vass, M.D., 176 pp. with 50 illustrations. Price \$5.00, Charles C. Thomas, 1951.

### **Renal Pelvis and Ureter.**

By Peter A. Narath, M.D., F.I.C.S., 429 pp. Price \$12.50, Grune & Stratton, Inc., 1951.

### **Radiologic Physics.**

By Charles Weyl and S. Reid Warren, Jr., 2nd edition, 491 pp. Price \$10.50, Charles C. Thomas, 1951.

### **The Healing Touch.**

By Harley William, 408 pp. with 8 illustrations. Price \$6.75, Charles C. Thomas, 1951.

A non-technical collection of biographies of famous physicians and a famous nurse.

### **A Manual of Orthoptics**

By Julia E. Lancaster, M.A., 200 pp. Price \$5.50, Charles C. Thomas, 1951.

### **Comparative Physiology of the Thyroid and Parathyroid Glands.**

By Walter Fleischmann, M.D., Ph.D., 78 pp. Price \$2.25, Charles C. Thomas, 1951.

### **Epileptic Seizure Patterns.**

By Wilder Penfield, M.D., and Kristian Kristiansen, M.D., 112 pp. with 18 illustrations and 9 tables. Price \$3.00, Charles C. Thomas, 1951.

### **Thyroid Function and Its Possible Role in Vascular Degeneration.**

By William B. Kountz, M.D., 62 pp. Price \$2.25, Charles C. Thomas, 1951.

### **Surgical Clinics of North America.**

Nationwide Number, October, 1951, pp. 1,257 to 1,580 incl., figs. 356 to 467 incl. \$18.00 per clinic year, cloth binding, \$15.00 per clinic year, paper binding, W. B. Saunders Co., 1951.

### **Outline of Fundamental Pharmacology.**

By David Fielding Marsh, 242 pp. with 19 illustrations. Price \$6.00, Charles C. Thomas, 1951.

### **Studies in Medicine.**

A Volume of Papers in Honor of Robert Wood Keeton, 396 pp. Price \$8.50, Charles C. Thomas, 1951.



# Hawaii Medical Service Association

## HMSA — YOUR ANSWER

In the course of his recent address to the Honolulu Chamber of Commerce, Dr. John Cline, president of the American Medical Association, paid high tribute to the Hawaii Medical Service Association (HMSA) for its accomplishments and in so doing gave the tip-off to HMSA's significance to the doctors of Hawaii.

He also strongly underscored the implicit threat of socialized medicine and detailed the burdens that such a legislation would impose on the medical profession as well as the taxpayer. In so doing he merely reiterated the facts which have become abundantly apparent to physicians and surgeons the world over; and by using as his illustration the state of chaos which has developed in England, as well as in other countries where socialized medicine has been essayed, he pointed graphically to the sad lot which has befallen the medical man under such government administration of medicine—not only from the standpoint of adverse influence upon the doctor's income, but also upon the efficiency of his service to the public where individual initiative has been withdrawn.

In the broadcast recently carried by ABC on the Mainland, and released in Hawaii by station KULA on December 10, Senators Taft and Byrd further castigated the thinking of the visionaries who would relegate the world's most honored profession to the damaging boondoggery which keynotes so many federally administered activities.

Blue Shield and Blue Cross Plans throughout the nation have proven their effectiveness beyond any doubt—not only from the viewpoint of the member, but from that of the attending physician. The Hawaii Medical Service Association, as a recognized leader among its related Mainland plans, has abundantly shown itself to be the doctor's answer to socialized medicine, whether the threat of such legislation be on a national scale or limited to the confines of the Territorial legislature.

It should be recalled that in 1947 the HMSA was the Hawaii doctors' firm answer to the legislators' consideration of an Island socialized medicine plan. At that time HMSA's membership numbered 9767. Today, with a membership of over 52,000, the argument in favor of such a pre-paid plan as that offered by HMSA is unquestionably stronger than ever.

There is little doubt that this view is shared

by the great majority of Island doctors and it is one which is gaining increasing popularity among far-thinking employers of labor who realize that participation in such a plan serves them well by serving their employees—that by providing their workers with economical pay-as-you-go medical, hospital and surgical protection it not only minimizes time loss from illness but improves the employee's mental attitude by supplying a sense of security born of freedom from fear.

Thus the HMSA protects its individual members *and* its subscribing employers, its service to both being measured in terms of its payments to the doctor, and to the hospital, for services rendered.

Additionally HMSA serves the local medical fraternity by eliminating, so far as its members are concerned, the element of uncertainty of remuneration. You, the doctor, are paid promptly and in accordance with a scale of prices agreed to by you (and HMSA's fee schedule is higher than any Mainland Blue Shield Plan). This is **SURE** money. No collections, no recourse to collection agencies, no payments involving five dollars now and five more "sometime later on." Most important, through the elimination of such collection tactics, you avoid the unfortunate relation with your patient which inevitably (though unfairly) results when you are forced to dun him for just—and often less than adequate—payment for services. Your patient remains your friend. Your patient had a free choice, and chose you as his family physician.

The continued successful functioning of the HMSA is largely dependent upon the cooperation of the physicians and the hospitals in rendering the services which HMSA assures to its members. This means fair service and wholly adequate service but **NOT** thoughtless or unconsidered service. Abuse of the plan by either the medical profession or the member can have but one very obvious result. The HMSA being a non-profit organization, the disbursal of benefit dollars must be kept within an intelligent ratio to its income as represented by paid-in dues. The moment the ratio becomes disproportionate, one of two things must result: either the plan must cease to function or the rates to its members must be increased to a point where the Plan will no longer offer—as it now does—the best buy to be had in medical, surgical and hospital protection.

J. R. VELTMANN  
*General Manager.*

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 313th regular meeting of the Hawaii County Medical Society was called to order by President T. David Woo at 7:30 p.m. Thursday, October 25, 1951, in the Library of Puumale Hospital with the following members present: Drs. Bergin, Brown, Carter, M. H. Chang, M. L. Chang, Crawford, Higa, Kasamoto, Kutsunai, Leslie, Loo, Matsumura, Miyamoto, Mizuire, Okumoto, Seymour, Woo, Yuen, and Steuermann. Guests present were Drs. Edward Wong, Stephen Tyau, and M. Glover.

Application of Dr. Robert Kaufmann for membership in the Hawaii County Medical Society was approved unanimously by secret ballot.

Following the business portion of the meeting a "Burn Symposium" was held under Dr. Grant Stemmermann, Pathologist at Hilo Memorial Hospital. Dr. T. Kutsunai also spoke on the subject.

\* \* \*

The 314th regular meeting of the Hawaii County Medical Society, which was a semi-annual affair, was called to order by President T. David Woo at 6:30 p.m. Thursday, November 24, 1951 at the Ka Lani Kai Restaurant in Kona. The following members were present: Drs. Kasamoto, Miyamoto, Kutsunai, Yuen, Loo, Woo, Hayashi, Seymour, and Fernandez. Since there were not enough members present to make a quorum no official business was taken up.

The evening was spent in dining and entertainment.

T. DAVID WOO, M.D.  
*Secretary pro tem*

## HONOLULU COUNTY MEDICAL SOCIETY

The Board of Governors of the Medical Society has for several months carefully studied the matter of entering into a formal contract with the HMSA. Particular attention was given to the Rules and Regulations for Participating Physicians. The original participating contract drawn was studied and altered in minute detail in collaboration with Dr. Faus, HMSA's Medical Director. Legal counsel was sought to determine the advisability of entering into a contract of this type.

The December meeting of the Society, sponsored by Tripler Army Hospital, was held on December 14, 1951 at 7:30 P.M., in the Main Conference Room of Tripler. There were approximately 55 members and guests present.

The following program was presented:

1. *Management of Tetany from Hypo-parathyroidism*—Lt. Col. Otto Wurl, Assistant Chief of Medical Service.
2. *Frequent Mistakes in Orthopedic Practice*—Col. Carl Rylander, Chief, Orthopedic Section.
3. *Cortical Hyperostosis Due to Vitamin A Poisoning*—Lt. Col. Walton Edwards, Chief, Pediatrics Section.

WILLIAM S. ITO  
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital on October 10, 1951 at 7:30 p.m. with acting president Dr. K. Kuhlman presiding.

Members present were: Drs. Kuhlman, Goodhue, Wade, Masunaga, Peter Kim, Kuhns, and Ishii. Resident physician Dr. Kim was also present.

An inquiry was made by Dr. Goodhue concerning Industrial Fee Schedule—whether or not the Fee Schedule has been formulated and if so when will it come into play. Dr. Wade's opinion was that the Fee Schedule is complete and that a compromise or an understanding among the parties involved must be made before it can be applied in practice.

Dr. Peter Kim, head of Mahelona Hospital, sought the members' opinions regarding the reporting of chest cases to physicians. Due to clerical shortage it was his recommendation that reports be made only when there was a change of status in the patient's condition. The Society unanimously agreed to this recommendation.

A letter from Dr. Fujii to Governor Skinner of Guam was read pertaining to 2 positions available to physicians. More details of the positions are awaited.

Dr. Wade suggested that Dr. Barnes, Professor of Urology, and Dr. M. Hill, proctologist, both of Los Angeles, be invited to speak to us. The members agreed to secure their services and set a special date for a meeting preferably on November 8.

CLYDE H. ISHII, M.D.  
*Secretary*

## MAUI COUNTY MEDICAL SOCIETY

A special meeting of the Maui County Medical Society was held at the Maui Grand Hotel on Friday, November 23, 1951 with Dr. E. Shimokawa presiding.

Dr. Stuart W. Harrington, Chief Surgeon at the Mayo Clinic, was present as a guest.

Dr. T. G. Lathrop, county health officer, brought up the matter of mass unipolar E.K.G. survey in conjunction with mobile chest x-ray survey next year and wanted to have the endorsement of the Society. After a short discussion, the Society endorsed a mass unipolar E.K.G. survey to be made simultaneously with the mobile chest x-ray survey next year, by a 10 to 7 vote.

Program chairman, Dr. McArthur introduced Dr. W. T. Dunn, who in turn introduced Dr. Stuart W. Harrington, who was the main speaker of the evening. His subjects were cancer of the breast and diaphragmatic hernia.

The Society endorsed the Nursing Case Institute on Poliomyelitis to be held February 29, 1952.

A letter from Dr. C. L. Wilbar, Jr. was read, stating that Governor Long has informed him that Governor Carlton Skinner of Guam is desirous of getting two physicians for the people of Guam. Anyone who would like to set up a practice in Guam should write directly to Governor Skinner.

Respectfully submitted,  
A. Y. WONG, M.D.  
For: ED. S. KUSHI, M.D.  
*Secretary*



# NOTES AND NEWS

## PERSONALS

Back from the American Academy of Ophthalmology and Otolaryngology are **Drs. L. Q. Pang, Tadao Hata, Phil Carbay, Wayne Wang, Clarence Kusunoki, Wilfred Minataya, and Ogden Pinkertan.**

**Dr. James R. Enright**, Chief of the Epidemiological department of the Territorial Board of Health, has attended a one week meeting of the American Public Health Association in San Francisco.

**Dr. Ira D. Hirschy**, formerly resident physician at Kalaupapa, has been appointed Director of the Territory's Hansen's disease division. Dr. Hirschy interned at Queen's Hospital in 1934-35. For the past year and a half he has been chief of the Army's Preventive Medicine Division in Japan.

**Dr. Jahn William Devereux** was awarded an honorary membership in the Nurses' Association, Territory of Hawaii, for his "sincere interest and excellent participation" as a member of the Board for the Licensing of Nurses, and for his participation in the Survey of Nursing Needs in the Territory.

**Dr. Robert B. Faus**, chairman of the Territorial Civil Defense Advisory Council, attended a defense planning conference of medical men in Chicago. Sponsored by the American Medical Association, American Hospital Association, and the Association of State and Territorial Health officers, the conference brought together officials from the entire nation to plan methods of survival during and after an atomic attack.

**Dr. Richard K. C. Lee**, assistant executive officer, Territorial Board of Health, has returned to Honolulu after a three month trip around the world.

**Dr. Bernard Schultz** has recently returned from an extended mainland study tour. While in New York City, Dr. Schultz participated in the first national meeting of the American College of Cardiology and has been elected the Hawaiian Representative to this organization. At the Cleveland Clinic, he attended a seminar on cardiology held by the American College of Physicians. At Ohio State University he heard Dr. Shaefer, heart specialist from Guy's Hospital, London, lecture on heart diseases. He also visited the Charity Hospital at New Orleans and stopped at Dallas, Texas, for the meeting of the Southern Medical Association.

**Dr. Jahn Felix** has returned from the mainland. Dr. Felix attended postgraduate lectures at the University of California, at the Cook County Hospital in Chicago, and at the Lahey Clinic in Boston. He also attended the meetings of the International College of Surgeons held in Chicago.

**Dr. and Mrs. Alvin Majaska** christened their second "baby," moored at the Waikiki Yacht Club, the Ehukai. The Majoskas, who are ardent sailing enthusiasts, extend a cordial invitation to all local physicians and their families who would like to go sailing. Bring your own Dramamine!

**Dr. and Mrs. Wayne Wang** welcomed a baby boy, their second son, on October 8, 1951.

**Dr. Marcus Guensberg**, Medical Director of the Terri-

torial Hospital, left for Mexico City in November to attend the International Conference on Mental Health.

**Dr. and Mrs. Joseph E. Strode** received word of the birth of a granddaughter, their second, born to their son and daughter-in-law, **Dr. and Mrs. Walter S. Strode**, presently of New Orleans, La.

**Dr. W. L. Aycock**, one of the nation's foremost authorities on poliomyelitis, a frequent Island visitor and the father of Mrs. Richard E. Dodge of Honolulu, died on October 24 at Boston, Mass.

**Dr. and Mrs. Austin V. Deibert** recently arrived here from Washington, D. C. Dr. Deibert is the new head of the United States Public Health Service in Hawaii, replacing **Dr. Leo Tucker**.

**Dr. and Mrs. Cecil Saunders** of The Queen's Hospital intern staff announce the arrival of a new son, their fourth, named Stephen.

**Dr. Darian Paskowitz**, acting Chief of the Bureau of Venereal Diseases and Cancer Control, has been elected the new President of the Hawaii Public Health Association.

**Dr. Robert A. Kimmich** recently joined the Territorial Hospital in Kaneohe in the capacity of Psychiatric Clinical Director. Dr. Kimmich, a graduate of the University of Indiana in 1943, was clinical instructor in psychiatry at Yale University School of Medicine prior to coming to Hawaii.

**Dr. Frank Spencer** has recently been elected to Fellowship in the American College of Surgeons.

Back in Honolulu in November for a short visit after an absence of many years were three kamaaina physicians: **Dr. Thamas C. McVeagh**, Director and Surgeon of the South San Francisco Hospital; **Dr. Alvin Daugan**, formerly of the Territorial Board of Health and presently in private surgical practice in California; and **Dr. Jae Jensen**, formerly of Pahala, Hawaii, and now of Huntington Park, California, practicing urology.

At the recent meeting of the Territorial Association of Plantation Physicians, **Dr. Clarence Carter** of Honokaa, Hawaii, was elected President; **Dr. William Wilkinson** of Lanai, Vice-President; and **Dr. Garton Wall** of Ewa, Treasurer.

**Colonel Frank Shaffer**, ear, nose, and throat specialist, joined the surgical staff of Tripler Army Hospital. Colonel Shaffer is a graduate of the University of Michigan (1936) and interned at Sibley Hospital, Washington, D. C. He comes to Tripler after a tour of duty at Beaumont Hospital, Fort Bliss, Texas.

The meetings of the Pan-Pacific Surgical Association prompted a great many colorful social affairs honoring visiting surgeons and their families. Among those who entertained local doctors and visitors were the staff of Tripler Army Hospital, **Dr. and Mrs. Ralph Claward**, **Dr. and Mrs. Harold Johnson**, **Dr. and Mrs. Laurence Wiig**, **Dr. and Mrs. Joseph Strode**, **Dr. and Mrs. Frank Spencer**, **Dr. and Mrs. W. J. Holmes**, **Drs. and Mesdames Robert and James Wang**, **Drs. and Mesdames K. F. Tom and S. Nishijima**, **Dr. and Mrs. F. J. Pinkerton**, **Dr. and Mrs. Robert Faus**, **Dr. and Mrs. Les Vascancellis**, **Dr. and Mrs. C. M. Burgess**, and many others.

**Dr. Sumner Price**, Medical Director of The Queen's Hospital, returned from the meetings of the American Hospital Council in St. Louis, and the Faculty of the American College of Hospital Administrators in Chicago in October. As Territorial delegate Dr. Price delivered 175 orchid leis to members attending the banquet in Chicago.

**Dr. Harry L. Arnold, Jr.**, attended a national conference of editors and business managers of state medical journals on November 12 and 13 at the A.M.A. headquarters in Chicago.

**Lt. Col. Orland S. Olsen**, a graduate of Northwestern University Medical School in the class of 1940, is the new Chief of Dermatology at Tripler Army Hospital, replacing **Lt. Col. Myles Moursund**. Lt. Col. Olsen has been in the Army since his graduation. He took his dermatologic training at Letterman Army Hospital and the University of California, and at the University of Cincinnati.

**Mr. Russell W. Tucker** is the new administrator at Kapiolani Maternity and Gynecological Hospital. Formerly a hospital administrator in Oklahoma City, Mr. Tucker has been administrator of Hilo Memorial Hospital for the past two years.

**Dr. Robert P. Henderson** has joined the staff of Puu-uaile Hospital in Hilo. A graduate of Duke University in 1944, Dr. Henderson trained at Harper and Herman Kiefer Hospitals in Detroit, followed by a tour of Army duty at Fitzsimmons Army Hospital and in Manila and at Ft. Sam Houston.

**Dr. Ian Martin Gunn**, a 1950 graduate of the University of Alberta, has joined the staff at The Queen's Hospital as Assistant Resident in medicine.

**Dr. Paul Caldwell**, a graduate of Temple University in the class of 1950, who interned at Passavant Memorial Hospital in Chicago, has joined the staff of the Waipahu Plantation Hospital. Dr. Caldwell spent two and one-half years in the Army prior to entering medical school, most of it in the European Theater.

**Dr. E. Richard Weinerman**, formerly Professor of Medical Economics at the University of California Medical School and at one time head of the Permanente Health Plan, came to Honolulu late in November at the invitation of the ILWU to conduct a survey of health programs in the sugar, pineapple and longshore industries here.

**Dr. and Mrs. L. Clagett Beck** announce the arrival of their first daughter on December 3. They also have two young sons.

## Hawaii

### Pan Pacific Surgical Conference

The Big Island was quite well represented at the Pan Pacific Surgical Congress in Honolulu. Those who were able to attend were: **Drs. William Bergin, C. L. Carter, C. Hayashi, T. Kutsunai, S. Mizuire, W. J. Seymour, G. Y. Tomoguchi, T. D. Woo, N. Steuermann** and **F. Irwin**. All reports indicated high praise and tremendous success of the Congress.

### Christmas Present a Little Early

Douglas Kim Wong arrived on November 26, 1951. The parents he picked are **Dr. and Mrs. Francis F. C. Wong** of Hilo. He has two playmates, a brother and a sister.

### Long Missed Doctors

At the time of the writing of these News and Notes reliable sources have it that **Dr. and Mrs. Archie Oren-**

**stein** will be back in Hilo on December 18, 1951. He will resume practice on January 2, 1952.

It is also understood that **Dr. Clyde Phillips** will be back in Hilo in mid-December.

### Hospital Surveyors

**Dr. Anthony J. J. Rourke** of San Francisco, president of the American Hospital Association and administrator of the Stanford Lane Hospital, and **Dr. Edward H. Leveroos**, associate secretary of the American Medical Association's council on medical education and hospitals, were in Hilo in November to conduct a survey of the Hilo Memorial Hospital. Dr. Rourke also spoke at a public hearing.

### Kauai

During the recent Pan Pacific Surgical Congress, the following physicians represented the island of Kauai: **Drs. W. Boyden, M. Brennecke, J. Kuhns, S. Wallis, and B. Wade**.

**Dr. and Mrs. Vernon Abbott** of Pontiac, Michigan were entertained with a dinner party by **Dr. and Mrs. Wallis**. During the war Dr. Abbott was stationed with the Marines on Kauai.

The Abbotts were also complimented at dinner by **Dr. and Mrs. Jay Kuhns** at their home in Wailua.

**Dr. and Mrs. E. Seymour Burge** of Evanston, Illinois, and **Dr. and Mrs. Harry Myron** of Tennessee were weekend guests of **Dr. and Mrs. Sam Wallis** of Lihue. Also invited were **Dr. and Mrs. R. Crosson** who visited Kauai during the week-end. Other doctors who were also guests that evening were **Dr. and Mrs. Nobu Masunaga, Dr. and Mrs. Patrick Cockett, Dr. and Mrs. Kenneth Fujii, and Dr. and Mrs. William Goodhue**.

*In very special cases  
A very superior Brandy*



*Specify*

84 Proof

**HENNESSY**

THE WORLD'S PREFERRED  
COGNAC BRANDY

Schieffelin & Co., New York N. Y.



# UMI MAKAHIKI I HALA\*

RCA Radiogram received December 9, 1941, 1:20 PM:  
WASHINGTON DC US GOVT 9 232P

HAWAII TERRITORIAL MEDICAL ASSOCIATION  
OFFICE OF CIVILIAN DEFENSE REQUESTS YOU URGE ALL  
HOSPITALS TO ESTABLISH IMMEDIATELY EMERGENCY  
MEDICAL FIELD UNITS IN ACCORDANCE WITH PLANS  
OUTLINED IN MEDICAL DIVISION BULLETINS NUMBER  
ONE AND TWO AND DRILL WEEKLY. WHERE NECESSARY  
RESERVE FIELD UNITS SHOULD ALSO BE ORGANIZED WITH  
MEDICAL NURSING AND TRAINED VOLUNTEER PERSONNEL  
DERIVED FROM THE COMMUNITY, URGE IMMEDIATE  
ACTION.

GEORGE BAEHR MD CHIEF MEDICAL OFFICER

Our reply, we hope, was adequate:

"For your information please be advised that our first emergency field unit was demonstrated with full equipment, ambulance and personnel on Army Day, April 4, and that since that time 18 such units, with a complement of 120 personnel each, have been trained and set up throughout the City of Honolulu.

"This was all done at the initiative of the Honolulu County Medical Society under the guidance and direction of **Dr. Robert B. Faus**, who has since been made a Major in the Army. Since April a committee of medical men voted in by the Medical Society, with **Dr. Harry L. Arnold, Sr.**, as chairman, has been devoting itself to the furtherance of these units and to the procurement of ambulances, equipment, etc.

"On the morning of December 7 these 18 units went into action within an hour, and the Preparedness Committee had 100 trucks rolling within an hour, some immediately, to go to the scene of combat at Hickam and Pearl Harbor for the transportation of casualties to the Army Hospital.

"Only two of our medical aid units had actual casualties, the details of which we would be glad to send you if you are interested, but all were in readiness to give full service. . . ."

*On December 7, 1941*

We had devised but not actually obtained any adequate system of air raid warnings. . . .

We had not agreed upon any adequate method of dimming the headlights and tail lights of automobiles for necessary night driving. . . .

No adequate preparation had been made for blacking out homes. . . .

Fire and air raid wardens had been recruited, but not adequately prepared for their special duties. . . .

Our store of blood plasma as is recounted at length elsewhere in this issue, was inadequate. . . .

Finally, our office of civilian defense existed only in skeleton form, and largely on paper. Only the medical defense offices, under the auspices of the Medical Preparedness Committee of our county medical society, were actually organized and operating. The inevitable

confusion that follows an enemy attack, makes the organization and establishment of a local O.C.D. many times more difficult then, than during "peace" time. The lesson is obvious.

*Before December 7, 1941*

"I had the opportunity of going over some of the arrangements your Society has made in respect to civilian casualty possibilities, at the request of the Office of Civilian Defense on the mainland, and when I go back and make my report I am going to say that your preparation here is much farther advanced than anything I know of on the mainland." . . .

*After December 7, 1941*

"Honolulu has been the proving ground for the technique of handling war wounds. I shall recommend that this technique be adopted universally throughout the country. . . . The United States of America owes you, the civilian doctors of Honolulu, a debt of gratitude for the work you did on December 7, and I shall make it known in high places what you did here."

DR. JOHN J. MOOREHEAD

"I WAS GREATLY PLEASED TO SEE WHAT A FINE JOB THE MEDICAL PROFESSION OF HONOLULU DID IN THE RECENT EMERGENCY. THE AID WHICH IT GAVE TO THE MILITARY FORCES OF THE ISLAND WILL ALWAYS BE A BRILLIANT CHAPTER IN THE HISTORY OF MEDICINE IN OUR COUNTRY. DR. ARNOLD AND DR. PINKERTON DESERVE THE HIGHEST PRAISE; SO TOO DO THE MANY CIVILIAN SURGEONS WHO SO SPLENDIDLY GAVE OF THEIR EFFORTS. THE VERY LOW MORTALITY WAS IN PART DUE TO THEIR COOPERATION. NO ONE WILL EVER DOUBT THE VALUE OF THE SULFONAMIDES AND OF PLASMA IN THE TREATMENT OF WAR CASUALTIES. THE EXPERIENCE HAS BEEN OF ENORMOUS HELP IN PLANNING FOR THE FUTURE. GREETINGS TO MY FRIENDS."

DR. I. S. RAVDIN, Philadelphia.

A kamaaina gathering of 300 physicians, their wives and their friends, honored **Dr. James T. Wayson** and Mrs. Wayson on the occasion of their 50th anniversary in medical practice.

**Dr. Thomas F. Fujiwara** has opened offices at 22 S. Vineyard Street.

**Dr. Harry Arnold, Jr.**, who left Honolulu December 4 by Clipper, was finally able to return through an order of the War Department authorizing the Army transport service to bring home any stranded Honolulu doctors. He arrived the middle of January.

**Dr. Alfred S. Hartwell** arrived the latter part of December to take up duties as medical resident at Queen's Hospital, coming from Massachusetts General Hospital.

**Dr. Douglas Murray** was ordered over from Maui into active service, and is stationed at the Kaneohe Hospital.

**Dr. James F. Fleming** of Paia, Maui, has also been called to Honolulu on active duty, and is stationed at the Japanese Hospital.

\* Ten years ago. From Volume 1, Number 3, January-February, 1942.

## Correspondence

### Sustained Antibiotic Administration in Hodgkin's Disease

#### To the Editor:

A case report, "Hodgkin's Disease Controlled by Chloromycetin" by Dr. Samuel R. Brown in the HAWAII MEDICAL JOURNAL for May-June 1951 calls for rather extended comment. The detailed case uniquely parallels one which appeared simultaneously (*Annals of Allergy*, 9:360 [May-June] 1951) in which the disease was apparently controlled by the sustained administration of terramycin. The latter is, like chloramphenicol ("Chloromycetin"), a streptomycetes-derived antibiotic. . . . The implication of this academic point will develop later but since it is gratifying for any medical discoverer to have confirmation, it should please Dr. Brown to know that his results are undoubtedly factual; that control of Hodgkin's and related lymphomas has been secured in a significant number of instances by the use of any of the streptomycetes-derived antibiotics. As will develop, there is reason to believe that these instances will increase along with expanding knowledge of the role of antibiotic therapy in the "adaptative" or "mesenchymal" diseases (among which there is reason for classifying Hodgkin's disease). For it appears that this application, to be proper, may be based on a phase of antibiotic activity not evinced during the usual use of the broad-spectrum antibiotics, as *chemotherapeutic agents* in the treatment of classic "infection." The effect on the leukoblastic processes such as Hodgkin's, the leukemias and plasmocytic myeloma seems to be of a different nature (*Lancet*, i, 1157 [May 26] 1951).

1. To date we have had supervisory care of 17 patients with histologically-proved (?) Hodgkin's disease and 4 with primary mediastinal tumors in which biopsy was impractical but which would pass rigorous scrutiny of our diagnostic assignment. Of the total of 21 patients, 6 were of the Pel-Ebstein type. All patients have been on some modification of the streptomycetes-derived antibiotic dosage schedule described below, though in most instances, in those cases of longer duration, various changes have been made in the schedule as our knowledge broadened.

Of the 21 patients, 9 lapsed from treatment because of unappreciated limitations of long-term antibiotic dosing which will be detailed. Of these, 6 died within a period of ten days to nine months after antibiotic discontinuance; in most instances after a purely elective transfusion or a course of nitrogen mustard, neither of which we now feel have any legitimate place in the management of Hodgkin's disease. Of the 12 non-lapsing patients, 3 died during protracted antibiotic administration. In the remaining 9, the disease is apparently under control while they continue an antibiotic ingestion regime. This control is adjudicated not on a statistical basis of survival (not enough time has elapsed for that) but on that of clinical appraisal, it being the type of "normality" that Dr. Brown described for his case.

2. Our present antibiotic dosage, which we contemplate continuing in each remissive case for the duration of the life of the patient, consists of a comparable amount inducing optimal growth in poultry. Needless

to say, the latter is *ingested* antibiotic and there is reason to believe that both the "animal protein factor" effect of antibiotics in these animals, as well as their capability of inducing remission in human mesenchymal disease, is conditioned by a change in the intestinal bacterial flora from a predominantly proteolytic to a saccharolytic type. Consequently we always give the antibiotic by mouth, never parenterally; even in the Pel-Ebstein type of Hodgkin's, the fever will usually abate within seventy-two hours after beginning the oral administration of 100 mg. daily of terramycin, chloramphenicol or streptomycin oleate in milk. However, since fecal flora reversion seems to determine the efficacy of the antibiotic, the choice is very important. I might remark in this connection that Dr. Brown could have met initial failure with chloromycetin but that aureomycin might then have worked, or vice versa; by coincidence, conditions happened to be favorable for fecal flora reversion in his patient, with the type and dosage of antibiotic employed. Others may report failures with chloromycetin only because the same set of conditions did not exist in their patient's intestinal tract. The choice and administration of antibiotic is a crucial factor in the management of lymphoma today and this will be dealt with first. (a) We routinely start with 250 milligrams of terramycin *base* and 6 grams of dried streptomycetes griseus residue which contains 300 gammas of a coliform suppressor antibiotic/gram (BiCon 3, Pfizer), per day. This antibiotic dose is not modified while the stool remains copious and odorless and gram-positive non sporulators (*lactobacilli*) predominate. If odor returns to the stool, indicating emergence of resistant proteolytic strains, 100 to 250 milligrams of chloramphenicol or streptomycin oleate are added to the daily antibiotic allotment. A word about "full scale" antibiotic dosage (25 to 50 milligrams per kilo) such as Dr. Brown employed and which one would naturally use in dealing with an "infective" process. The theoretical considerations behind the *fact* that a larger proportion of patients do better on a smaller dose of antibiotic (2 to 5 milligrams per kilo) are dealt with in published animal nutritional studies; here we can only advise the smaller dosage on the basis of our own experience.

(b) From one pint to one quart of milk per day should be ingested. If salt restriction is advisable (*vide infra*) it should be dialyzed. It is an important part of the treatment since it facilitates coliform suppression in the intestines through gram-positive organism implantation.

(c) Ammonium chloride, 6 grams and potassium chloride, 3 grams, are started daily along with the antibiotic dosage and continued indefinitely. This adjuvant was introduced after sad experience had taught that the Hodgkin's patient might go into rapid remission on antibiotic ingestion only to die from congestive heart failure due to sodium and water retention and potassium depletion accompanying the remission. The same sequence has followed remission induced by the adrenocorticotherapeutic agents, cortisone and ACTH, and the mechanism of antibiotic-induced "adrenocorticomimetic" effect is dealt with, theoretically, in other publications (*N. Y. State J. Med.*, 51:1739, 1951).



(d) A high-fat, low protein diet is employed throughout. A high-fat contribution was uncovered accidentally and we can simply offer that our best survivals have been in the group getting 1200-1500 calories/day in the form of fat. This is facilitated by adding one of the newer, tastier emulsions such as Upjohn's Lipomul to the milk; earlier we had used peanut oil emulsified in milk with Tween 80. The high fat complement, along with the milk, leaves little room for additional protein but here again, adverse experience taught us that a *low-protein diet* is better. If limitation of protein in a cachexic disease seems to insult the intelligence, we now have confirmatory information from experimental sources that a high protein intake may reinduce a proteolytic intestinal flora and undo what good the antibiotic is doing (*N. Y. State J. Med.*, 51:2121, 1951).

There remain specific questions by Dr. Brown which I will attempt to answer. "Would this result (quoting from Dr. Brown's report) tend to transfer this case of Hodgkin's disease from the neoplastic to the infectious group, or, conversely show that this antibiotic, chloromycetin, has an effect on the metabolism of neoplastic cells?"

The nature of Hodgkin's, like that of any mesenchymal disease still is debatable though there is increasing tendency to consider such mesenchymal proliferation as a response to tissue "sensitization." Some statistics are in fact being assembled to indicate that Hodgkin's like other mesenchymal proliferative disease (periarteritis nodosa, disseminated lupus), occurs most frequently in "allergic" reactors; that mesenchymal proliferation is an expression of such reactivity. The "infectious" and "neoplastic" natures of these mesenchymal proliferations can actually be resolved if one considers that infecting organisms might be the "allergenizing stimulus." And there is now a definite tendency toward channeling work with antibiotics, with such connotation of eliminating "sensitizing" organisms (see Brown, T. MCP., et al., *Am. J. Med. Sci.* 221:618, 1951) into broad phases of cancer research.

On the other hand we have the startling revelation that antibiotics do other things than overcome "infection"; they are now being fed as a ration to many domesticated animals in many countries who are, in consequence, growing at a much better rate than formerly. Are we to assume that until last year, when the general feeding of antibiotic to animals became established, that they were all "infected" and for that reason did not grow as well (*M. Times*, 79:94, 1951)? From the clinical side there are equally disturbing reports threatening our staid concepts of how antibiotics work and why. The clinical efficacy of antituberculous agents is

showing no correlation—in fact quite the reverse—with the in vitro tuberculostatic activity (*M. Times* (Corr.) June, 1951). Streptomycin is devoid of in vitro "virocidal" activity yet has been found clinically effective in a number of "virus" diseases. Finally, Mosonyi and his co-workers (*Lancet*, ii, 81, 1951) have promised indubitable evidence for the fact that the clinical effect of the streptomycetes-derived antibiotics bears no relationship whatsoever to infection by organisms susceptible to these antibiotics. So, the effect on Hodgkin's which Dr. Brown and I have observed does not necessarily rule in or rule out the "infectious" component. Likewise, any effect of antibiotics on definitive "cancer" may be by virtue of the systemic implication of "animal protein factor" activity, rather than an assumed action on some enzyme within the neoplastic cell.

"Would x-raying of the former gland areas be advisable—comparable to postoperative radiation in cancer of the breast?"

We use x-ray therapy, along with sustained antibiotic administration, where there is urgency for the more rapidly induced local resolution. In view of our concept of the leukoblastic process as a *reactive* proliferation to a systemic stimulus, and presuming the latter to be removed by antibiotic ingestion, we see no reason for post-resolution radiation. Residual glands during successfully applied antibiotic therapy, are usually completely fibrotic and inactive and shrink little further on x-ray application. On the other hand, there should be less hesitancy about using x-ray in the antibiotic-ingesting Hodgkin's patient, because just as antibiotic ingestion prolongs life in irradiated animals (Hammond, C. W., & Miller, C. P., *Ann. N. Y. Acad. Sci.*, 53:303, 1950) it likewise prevents the hemopoietic depression consequent on such therapy (*N. Y. State J. Med.*, 50:1852, 1950). All our patients now receiving radiotherapy for any reason, are kept on the identical antibiotic and dietary schedule, outlined for the maintenance of the Hodgkin's patient.

As a corollary to the matter of x-ray, the use of such cytotoxic agents as nitrogen mustards or triphenylmelamine (TPM) calls for comment. In line with Dr. Brown's experience, our own observations on them, as in the comparable case of the "antifols" in leukemia, has been decidedly bad; I know of no instance of life or comfort prolongation through their use, but of many of the converse where they killed patients who might have responded to more rational therapy. I believe Dr. Brown's modality to represent the latter and to thus merit further development and exploitation.

ROBERT D. BARNARD, M.D.

138—231st St.  
Laurelton, New York.

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

---

## BULLETIN COMMITTEE

LAURA DRAPER, *Editor*, Board of Health, Honolulu

LEAH BIGALOW, *Nursing Information Committee*, St. Francis Hospital, Honolulu

LEONA ADAM, *Executive Secretary*, Honolulu

ISABEL MEDEIROS, *Territorial Association Secretary*, Honolulu

### *Secretaries*

MARGARET BARNETT, Hawaii  
VIRGINIA RAUTENBERG, Honolulu  
PAULINE JOHNSON, Kauai  
JOANN GROBERG, Maui

### *Publicity Chairmen*

EDNA BALDWIN, Hawaii  
TSUGU KADOTA, Kauai  
ELIZABETH MCCALL, Maui

---

## EXECUTIVE SECRETARY APPOINTED

MISS LEONA ADAM has recently been appointed to be Executive Secretary of the Nurses' Association, Territory of Hawaii, Inc. and Board for the Licensing of Nurses. Miss Adam is a graduate of the Protestant Deaconess Hospital, Evansville, Indiana and received her B.S. from Indiana University and her certificate in public health nursing at Western Reserve University.



MISS ADAM

She has had experience as school nurse, public health staff nurse and as district supervisor and consultant to the Indiana State Board of Health. Just before coming to the islands one year ago, Miss Adam was public health nursing coordinator at St. Vincent's, Indianapolis.

Miss Adam has filled many state offices. She was a member of the Indiana State Nursing Council for War Service; chairman of the State Committee on Recruitment of Students for Schools of Nursing; chairman of the Committee on Constitution and By-Laws of the Indiana State League of Nursing Education, and Vice President and President of the Indiana State Nurses' Association.

During the year Miss Adam has been in Hawaii, she has been with the Department of Health as public health staff nurse at Kaneohe.

## PRESIDENT'S ADDRESS AT ANNUAL MEETING OF HOUSE OF DELEGATES, N.A.T.H., 1951

ARLENE THOMPSON, R.N.

At the last annual meeting, your officers and members of the Board were given several responsibilities to assume and if possible work out during the year 1950-1951. With the assistance of our Executive Secretary, Mrs. Norman, we have tried to the best of our ability to meet these requests.

Social Security for all hospital employees seemed to be the first in importance. As an Association, we were requested to initiate activity as necessary to assist in this program. Information was given when requested, and I believe that today most of us enjoy the privilege of Social Security.

One dollar per active member has been sent to A.N.A. toward a special research fund. This was the first payment of our five year contribution.

Your Board was asked to assume immediate leadership in the implementation of an economic security program. Assistance in this program was given to us by Miss Shirley Titus. As you recall, ballots were sent to each active member. In order to establish such a program, the result of the ballot had to be 51% in favor of this move. Of the 491 active members entitled to vote, only 237 ballots were cast of which 199 were favorable. This gave



us only a 48% vote in favor of the Economic Security program. Harriet Kuwamoto represented Hawaii at the Economic Security Workshop in June. We present this problem again to the members of this Convention for further consideration and action.

The theme of your annual meeting, "Preparedness," may have been chosen as part of another of our responsibilities—that of Disaster Relief. As our representative, Margaret Nott is serving on the Red Cross Disaster Preparedness Committee; Virginia Jones and Laura Draper are serving on the Disaster Relief Agency's Committee. In February of this year Virginia Jones, Rosie Kim Chang and Virginia Ahrendt attended the Atomic Nursing Course conducted by the National Security Resources Board in San Francisco. As part of the program which followed, the Hawaii League of Nursing Education acting as our Educational Committee prepared and completed August 13, 1951, a refresher course for nurses. On the ballot sent to active members a note was added asking each nurse to take if possible a refresher course in First Aid. We need nurses to assist in teaching Red Cross Home Nursing and Nurses' Aid classes.

We have taken an active part in legislation this year and as the request of the last resolution of our 1950 convention, that of appointing three nurses to assist on a special committee to lay the ground work for a survey of nursing resources and education facilities in the Territory, Miss Mary V. Cheek, Miss Virginia Jones, and Mrs. Hatsumi Ishikawa were chosen to serve. The three members chosen by the League to serve were: Miss Alison MacBride, Mrs. Rosie Kim Chang, and myself. This committee of about 25 members worked very diligently under the leadership of Alison MacBride in preparing for this survey. Miss Ruth Gillan, consultant, spent several weeks in Hawaii and the survey was completed in April, 1951. The expenses of the survey were paid by the Board for the Licensing of Nurses. Recently our Governor appointed a special commission to study the findings and the recommendations of the survey.

We have started on a long range reorganizational problem this year. As the result of much study the following changes have been made:

1. Illa Storme was made Registrar of the Nursing Service Bureau and Physicians' Exchange thus relieving the Executive Secretary of this responsibility.
2. The bookkeeping for the Territorial Nurses' Association, Nursing Service Bureau and Physicians' Exchange are being done on a monthly basis by a professional bookkeeper.

3. The treasurer of Nurses' Association, Territory of Hawaii and Registrar of Nursing Service Bureau have each been bonded for \$1000.
4. Our bonding policies, Articles of Incorporation, etc., are reposing in a safe deposit box at the Bishop Trust Company.
5. Our employees are covered by workmen's compensation, have Social Security, and Personnel Policies which are to be reviewed yearly.

With the resignation of Mrs. Norman, our Executive Secretary, effective June 22, 1951, your officers have had to assume greater responsibilities. Mrs. Grace Page, who was employed as a part-time clerk-typist, was placed on a full time basis. Mrs. Page has carried the responsibility of the office and has been untiring in her assistance to us. We appreciate her loyalty and understanding of our situation.

At this time may I express my appreciation to each person who has assisted in our association this year. As you hear your committee reports you will see the effort and time that has been spent in our behalf.

As part of our long range plan we present to you for consideration:

1. The transferring of the administration of Nursing Service Bureau and Physicians' Exchange to the Oahu District Nurses' Association.
2. That until the Oahu District can assume financial responsibilities the Territorial Nurses' Association continue to pay \$1.00 from each membership fee to Nursing Service Bureau.
3. That in the coming year all sections organize on a Territorial basis so that we may have representation at the workshops and conferences sponsored by A.N.A. We were unable to send a Private Duty Nurse and a Public Health Nurse to a workshop this last September.
4. With the six nursing organizations joining into two, changes in the structure were necessary. As these changes are made on a national level, it is then necessary for us on a state or territorial level to also make such changes so that we may have a smooth running organization and take advantages offered to us by A.N.A. As A.N.A. has organized sections according to the nurses' work status, so we on a state level should do the same. This is necessary in order to proceed with the Economic Security Program. Time has been set aside on Thursday for nurses of the various groups to meet if interested in forming a Territorial Section.\*

An organization cannot stand still; it must advance or retreat. Your officers and members of the Board stand ready to carry on in the work necessary to make our professional nurse organization one of service to all nurses. We need *your* support.

\* NOTE: In accordance with the arrangements made by the President, nurses of various groups met and initiated the organization of sections. These are administrative, general duty, industrial, private duty and public health.

## NEW OFFICERS FOR NURSES

Attendance at the 1951 annual meeting of the Nurses' Association, Territory of Hawaii was 409, including 207 students. Votes were cast by all the 63 delegates (or their alternates).

The Nurses' Association, Territory of Hawaii Board of Directors, with its new members, now is composed of:

President: MRS. ARLENE THOMPSON, Director of Nurses, Children's Hospital, Honolulu  
 First Vice President: SISTER MARY ALBERT, Director of Nurses, St. Francis Hospital, Honolulu  
 Second Vice President: MRS. ROSIE K. CHANG, Educational Director, Queen's Hospital, Honolulu  
 Secretary: MRS. ISABEL MEDEIROS, Acting Director of Nurses, Kuakini Hospital, Honolulu  
 Treasurer: MRS. BERNADETTE NAKAHATA, St. Francis Hospital, Honolulu  
 Directors: MARY JEAN MACDONALD, Hilo, Hawaii; THELMA HENSLEY, Kealia, Kauai; MRS. LOIS BELL, Honolulu; ROSE LITTEL, Puunene, Maui; HARRIET KUWAMOTO, Honolulu; MRS. HAZEL RICHARDS, Honolulu

The League of Nursing Education met concurrently with the Nurses' Association, Territory of Hawaii. Their Board of Directors now is composed of:

PRESIDENT: ALISON MACBRIDE, Department of Health, Honolulu  
 Vice President: OLIVE BENSON, Territorial Hospital, Kaneohe  
 Secretary: MRS. ANNE CAMARA, Leahi Hospital, Honolulu  
 Treasurer: LORETTA SCHULER, Red Cross, Honolulu  
 Directors: SISTER MARY ALBERT, Honolulu; MRS. ROSIE CHANG, Honolulu; MARY V. CHEEK, Honolulu; AIKO YANO, Honolulu

## TERRITORIAL HOSPITAL PLAN

VERGIL F. BRADFIELD<sup>1</sup>

Hospitals for thousands of years were founded by the promptings of FEAR, SYMPATHY, RELIGION. As civilization progressed there was an added reason called CIVIC CONSCIOUSNESS.

From the dawn of time, man as an individual has been prone to offer his favorite remedy for the relief of his neighbor when ill and suffering. But it was only as civilization advanced from the individual through the family, beyond the tribe to the organized community, that common responsibility for the unfortunate becomes recognized. It is only with a progressive civilization that man seeks to provide for the welfare of fel-

low-beings other than those who comprise his own family.<sup>2</sup>

The first real hospital in Hawaii was opened by Americans for seafaring men in 1837 at Waikiki.

Similar marine hospitals were established in the Honolulu area by the French and British in the 1840's.

In the middle 1850's a City Hospital was individually owned and operated for a short time.

The Queen's Hospital was organized in 1859, largely as a result of the efforts of King Kamehameha IV.

Government established the Kalaupapa Settlement and Kalihi Receiving Station for Hansen's disease sufferers, and an insane asylum, in the 1860's.

Malulani, the first government district hospital, was opened on Maui in 1884.

A small cottage hospital sponsored by Government at Koloa, Kauai, in 1888 was closed in 1903 because no patients applied for admission for two years.

Kapiolani Hospital, Honolulu, began in 1890.

In 1895 the residents of the Waimea District on Kauai built and operated a small general hospital.

Shortly before and after the turn of the century, several small proprietary or individually owned and operated hospitals were established in urban areas. None of them continued for long.

The Hilo Memorial Hospital was opened by Government in 1897.

Passing over fifty years of local hospital history (see "Hospital Costs in Hawaii," Public Health Committee, Chamber of Honolulu, 1949) to the Territorial program for construction of hospitals and health centers to furnish adequate services to all of the people:

In 1946 Senators Hill and Burton prevailed upon the 79th Congress to pass "The Hospital Survey and Construction Act," being Public Law 725. The U. S. Public Health Service set up regulations in accordance with the Act, compliance with which enabled States and Territories to benefit.

Three requirements were the designation of a single agency to administer a hospital plan, the creation of an advisory council and a law with rules and regulations for inspection and licensure of hospitals and related institutions. The Territorial Board of Health was designated as the agency. A Hospital Advisory Council was appointed. Regulations for hospitals were promulgated under the provisions of an existing law

<sup>1</sup> Assistant Director, Division of Hospitals and Medical Care, Territorial Department of Health.

Read at the annual meeting of the Nurses' Association, Territory of Hawaii, Inc., and the Hawaii Chapter, National League of Nursing Education, October 18, 1951.

<sup>2</sup> A statement by Dr. Malcolm T. MacEachern in his book on Hospital Organization and Management.



(Section 2015, Revised Laws of Hawaii, 1945, as amended).

The Territory was granted \$10,000 in 1947 for the purposes of an inventory of existing hospitals and public health centers, for a survey of the need for construction of such facilities and for developing a program.

The Federal grants-in-aid for construction have been made to the Territory as follows:

Fiscal year 1948.....	\$ 222,758.00
1949.....	261,868.00
1950.....	500,884.00
1951.....	282,740.00
1952.....	249,930.00
	<b>\$1,518,180.00</b>

These funds have been allocated to the following projects:

Puumaile Hospital, about 1/6 of the cost (new)...	\$ 383,720.83
Central Maui Memorial Hospital, about 1/2 of the cost (new, to replace Malulani Hospital).....	565,428.66
Kuakini Hospital, 50% of the cost (a replacement of non-acceptable buildings).....	386,680.93
Hanapepe Health Station, 50% of the cost.....	17,500.00
The Queen's Hospital, 50% of the cost of improvements and expansion of service departments .....	164,849.58
	<b>\$1,518,180.00</b>

It had been hoped that annual grants to the Territory of approximately a half million dollars would continue after 1950 but the national defense program interfered with the earlier plan for the Congress to appropriate \$150,000,000 a year for participation in the over-all state construction programming.

1951 inventory of Territorial health facilities in five categories (general, chronic, tuberculosis, mental health centers and auxiliary units) and with five classes of ownership (Territorial, County, Non-Profit Association, Corporation, Individual):

	GENERAL HOSPITALS					CHRONIC FACILITIES					TB	MENTAL
	Terr.	County	NPA	Corp.	Ind.	County	NPA	Corp.	Ind.			
Oahu	1	....	9	3	....	1	1	....	4	1	2	
Hawaii	....	4	....	2	4	1	....	....	....	1	....	
Maui	....	3	....	2	....	1	....	1	....	1	....	
Kauai	....	....	1	1	....	....	1	....	....	1	....	
Molokai	1	....	1	1	....	....	....	....	....	....	....	
Lanai	....	....	....	1	....	....	....	....	....	....	....	
Territory	2	7	11	10	4	3	2	1	4	4	2	
Total			34					10				
1947-48	2	6	9	18	6							

There are 39 "regular" hospitals in the Territory.

The Territory, with a total non-military population of 475,475, is divided into hospital service areas<sup>3</sup>:

<sup>3</sup> Taken from 1951 Revised Report of Hospital Survey & Planning, page 13.

Oahu—civilian population 329,567  
 Base Area No. 1—population 277,124 with teaching hospitals located in Honolulu  
 Rural Area No. 1—population 24,923, comprising the plantation communities of the Waianae District and the plantation communities in the Ewa District, somewhat remote from Honolulu  
 Rural Area No. 2—population 27,520, combining the Wahiawa, Waiialua and Koolauloa Districts  
 Hawaii—population 67,683  
 Intermediate Area No. 1  
 Maui—population 40,317  
 Intermediate Area No. 2  
 Kauai—population 29,838 with two distinct geographical areas  
 Rural Area No. 3—population 17,283 including Koloa  
 Rural Area No. 4—population 12,555  
 Molokai—population 4,939  
 Rural Area No. 5  
 Lanai—population 3,131  
 Rural Area No. 6

Bed quotas set up by the U. S. Public Health Service are as follows:

	GENERAL	CHRONIC	TUBERCULOSIS	MENTAL
Base areas	4.5 per 1000			
Intermediate areas	4 per 1000			
Rural areas	2.5 per 1000			
Territory-at-large	4.5 per 1000	2 per 1000	2.5†	5 per 1000
Needed beds according to above quotas	2,129	951	448	2,377
Existing acceptable beds	1,208	255	1,231	1,115
Additional beds needed according to above quotas	921	696	0	1,262

† Per average annual deaths for past 5 years.

#### STATEMENT REGARDING ALLOCATION OF POOL BEDS FOR GENERAL HOSPITALS<sup>4</sup>

Bed needs of an area's population are first calculated on the basis of 4.5, 4 and 2.5 beds per 1,000 persons in base, intermediate and rural areas respectively. Then any special circumstances in the area are studied (according to principles for distribution of pool beds) and extra beds from the pool are allotted to the area if the need is indicated. The information presented below outlines the area needs and clarifies the allotments of pool beds to certain areas.

##### Region I

*Base Area 1—Part of Honolulu County, including the City of Honolulu*

The estimated population of this area, excluding military personnel is 277,124. It is entitled, according to 4.5 ratio per 1,000 population, to 1,247 beds. An additional 183 beds from the pool have been allotted to this area because the pattern is to refer patients from the other islands needing care which is not available in their own localities.

##### *Intermediate Area 1—Hawaii County*

This area with a population of 67,683 at a ratio of 4 beds per 1,000 population is entitled to 271 beds. The county now has 183 existing acceptable beds. Therefore, 88 additional beds may be constructed. No pool beds have been added to this area as it is believed the 88 additional beds will provide adequate general hospital services.

##### *Intermediate Area 2—Island of Maui*

The population of this area is 40,317. The bed allowance, according to 4 beds per 1,000 population, is 161 beds. There are now 157 existing acceptable hospital beds. This includes the new Central Maui Memorial Hospital, which is under construction at the present time.

<sup>4</sup> Taken from 1951 Revised Report of Hospital Survey & Planning.

The 4 additional beds which may be built on this island have been assigned to Hana for purposes of replacing non-acceptable facilities, with a small clinic to take care of out-patient services and provide these few beds to take care of emergencies.

#### *Rural Area 1—Part of Honolulu County*

The center of plantation population numbering 24,923 is in the Ewa District at Waipahu where a community hospital of 62 beds is projected to take the place of two existing non-acceptable hospitals having a combined capacity of 96 beds. No pool beds are allocated to this area at present.

#### *Rural Area 2—Part of Honolulu County*

The plantation districts of Wahiawa, Kahuku and Waialua and communities along part of the northeast coast have an estimated population of 27,520. For geographical and economic reasons, it is presently desirable to plan for a 69-bed community hospital at Wahiawa to replace three non-acceptable hospitals at Wahiawa, Kahuku and Waialua having a total of 129 beds. No pool beds are allocated at present.

#### *Rural Area 3—Eastern Section of Kauai County*

The population of this area comprising Hanalei, Kaiwaha and Lihue Districts and the Koloa community is estimated as 17,283. It is entitled to a bed allowance of 43 on the basis of 2.5 per 1,000 population. There is need for the time being, however, for 54 general hospital beds at Lihue. The Wilcox Memorial Hospital with 94 beds can assign 40 for the care of chronics. No pool beds are required.

#### *Rural Area 4—Western Section of Kauai County*

The population is estimated as 12,555, distributed over the Waimea District and a part of the Koloa District including the plantation communities in and around Lawai, Elele, Hanapepe, Waimea and Kekaha. Resident physicians and surgeons in this area have indicated that a 48-bed hospital replacing the present crowded and unacceptable 36-bed hospital at Waimea would adequately serve present needs. A quota of 31 beds would be increased by 17 pool beds. Industrial accidents and general surgery contribute to the rather high incidence of hospitalization in this area.

#### *Rural Area 5—Island of Molokai*

This area, with a population of 4,939, would be entitled to 12 beds. They have no existing acceptable beds. Thirteen beds have been assigned from the pool to permit the construction of a 25-bed facility. Due to the fact that transportation schedules are infrequent to the island of Molokai, more complete service is required on this island. Referrals for specialized services will be made either to Maui or Honolulu.

#### *Rural Area 6—Island of Lanai*

The population of 3,131 provides 8 beds for this island. An additional 12 beds have been allocated from the pool in order to make possible a 20-bed facility. Due to the infrequent transportation schedules to the island of Lanai, more complete service is required on this island. Referrals for specialized services will be made either to Maui or Honolulu.

The existing acceptable general hospital beds are 53% of the recognized need. There are 3,809 acceptable beds of all categories in the Territory, 64% of the total needed, a shortage of 2,096 beds. Existing non-acceptable

beds total 1,064 and should be replaced as soon as financial sponsors can be found.

### STANDARDS ADOPTED FOR DETERMINATION OF ACCEPTABLE AND NON-ACCEPTABLE HOSPITAL BEDS<sup>5</sup>

Generally speaking, "non-acceptable" beds are those in a hospital or in a portion of a hospital, which is considered a "public hazard," and which "endangers the public safety," and may, therefore, include its entire bed capacity or only a portion thereof. The "physical condition" and other factors, which the Territorial Advisory Council on Hospital Survey and Construction considered in the determination of non-acceptability include:

1. Structure not fire resistant.
2. Old dilapidated building.
3. Proven natural hazards, tidal waves, storms, etc.
4. Capacity too small for type of services or economical operations.
5. Inadequate facilities for medical records maintenance.
6. Inadequate facilities for storage of supplies.
7. Inadequate facilities for laundry service.
8. Inadequate facilities for dietetic service.
9. Inadequate facilities for laboratory service.
10. Inadequate facilities for x-ray services.
11. Inadequate facilities for pharmacy service.
12. Inadequate facilities for operating section.
13. Inadequate facilities for obstetric deliveries.
14. Inadequate facilities for nurseries.
15. Inadequate or no regular physician attendance.
16. Inadequate or no trained nursing service.
17. Inadequate nurses' quarters.
18. Inadequate employees' quarters.
19. General obsolescence.
20. Closure of hospital has been decided.

NOTE: Because one-hour fire-resistant construction is a minimum requirement for one-story hospital buildings seeking federal aid under P.L. 725, it is necessary to designate such existing buildings which are not fire-resistant as "non-acceptable." This does not mean that such an existing building will be condemned or prevented from operating. Proposed Territorial Hospital rules and regulations will permit their operation for a reasonable length of time, but will stipulate fire-resistant construction for new structures or replacements. Furthermore, these "non-acceptable" beds increase the number of beds which will be constructible "with federal aid."

### NEEDS<sup>6</sup>

CATEGORY	EXISTING ACCEPTABLE BEDS	TOTAL BEDS NEEDED	PERCENT OF NEED MET
General.....	1,208	2,129	58%
Tuberculosis.....	1,231	448	100%
Mental.....	1,115	2,377	47%
Chronic.....	255	951	27%
	3,809	5,905	
Public Health Centers	2	17	12%

<sup>5</sup> Taken from 1951 Revised Report.

<sup>6</sup> Taken from 1951 Revised Report.

**Whenever you change your address,  
please be sure to notify**

**Mrs. Grace Page, Office Secretary  
Nurses' Association, Territory of Hawaii  
Mabel Smyth Building  
510 South Beretania Street  
Honolulu, Hawaii.  
Phone: 6-8630**



## NURSING IN PANAMA

I.I.A.A., c/o U.S. Embassy,  
Box 2016, Balboa, Canal Zone,  
November 17, 1951

Dear Friends:

The past year was a very difficult and busy one for me, but I enjoyed the job in Washington and would have liked to stay there until the end of the summer. However, my new agency was so eager to fill this position in Panama that they gave me no peace until I agreed to come here in July. Prior to that, I took a three weeks' course at the Foreign Service Institute of the State Dept. That was interesting and a good preparation for work in a foreign land. I had quite a scramble to wind up all my affairs in Washington and prepare for a two-year assignment in Panama. But I finally got through it!!! I came down here by boat—41½ days—but did not enjoy the trip very much because the ocean was rough and there was not much activity aboard.

My job here is: Nursing Consultant, Health and Sanitation Division, Institute of Inter-American Affairs. This is part of the "Point 4" program of aid to underdeveloped countries and I am thrilled to be a part of it. There are four of us in Health and Sanitation and eight in the educational division. All are fine people. We head up to the Embassy here, so get in on some of the Embassy functions.

Most of my time at present is devoted to the 850 bed Santo Tomas General Hospital. They have a School of Nursing of 170 students, although have facilities for only 75. Standards of education and of patient care are comparatively low. Equipment is poor and sometimes we have more patients than beds. My first job is to try to improve the organization of the hospital—not an easy task. The hospitals and all health programs are run by the government so politics is mixed up with everything. We have a new set of politicians in power since the revolution in May and they seem to be interested in improving conditions. I have helped to write the new "Decreto" for the Hospital, which is to go before the Assembly in October. If it passes, progress will be more rapid. We are also working on a Civil Service law for the nurses to provide more stability to their positions.

I find the whole situation to be fascinating and I think there are many things I can accomplish, in spite of the many problems. My greatest handicap now is not knowing the language, but I am studying it constantly and hope to be fairly fluent within a year.

For a month I lived in a hotel, but now have a spacious apartment in Panama City with a new friend. Living here has many complications, of which the heat and mold are not the least! Getting anything done, even the weekly household shopping, takes twice as much time and patience as in the States. We have a maid who is very good. She cooks our lunch every day, for we are able to come home for an hour at noon. She also does all the housework, so we are free to use our energies in other directions.

Social life is quite active and we go out and entertain a good deal. Also, this is the "Crossroads of the World" and many people come through, so we frequently have to meet 2 A.M. planes or put people on planes in the middle of the night. I also have quite a few activities at the hospital in the evenings or over week-ends. And

I go to the meetings of the nurses in the Canal Zone, too. Whatever free time I have is devoted to the study of Spanish. So it is a busy but interesting life.

So far I have not seen much of the interior of the country, except for one wonderful week-end trip by cabin cruiser to the jungles down near the Columbian border, and a trip down the Atlantic coast to a small isolated town for the fiesta-day of the "Black Christ." This latter ceremony is one of the most impressive I have ever seen, beginning at sundown in a large and beautifully decorated church and culminating in a candle-lit parade lasting until midnight. In the center of the parade, a deeply religious affair, was the very large and lovely statue of the Saint—the "Black Christ"—carried on a candle-lit platform by 80 young men who struggled with each other for the honor of helping to bear this precious burden. Before them walked a large number of people, backwards, carrying candles, incense and crosses. Some were dressed in flowing robes to match that of the Saint. Following the statue were more people with candles and a small orchestra which played constantly a haunting musical theme, half pagan, half Christian. All the people swayed rhythmically to this music, including the men carrying the figure, moving ahead a few paces, then backwards a few steps. This backward-forward movement was necessary to make the procession last 4 hours although the town is only 4 blocks long! The atmosphere of religious fervor was most stirring. It was an experience I shall never forget. We reached home at 6:30 on Monday morning, just in time to get to work at 7:30, but it was certainly worth it. We hope to have more such trips in the future.

There is much beauty here, as in Hawaii, although not many flowers. There is little agriculture carried on but an agricultural program is being set up. And of course there is no industry except the Canal Zone which has always pretty well supported the country.

The heat here is not so bad as Washington, D. C., in the summer but it goes on longer. It is definitely hotter than Hawaii, but is supposed to be drier and cooler in Jan., Feb., March. Now it is "winter," the rainy season, but we have not had a great deal of rain. Everything is turned around in Panama—even the sun, which rises in the Pacific and sets in the Atlantic Ocean!

Greetings to all my friends in Hawaii.

Sincerely,  
CHARLOTTE KERR

*Miss Kerr, formerly active in nursing education in the Territory, is now employed by Institute of Inter-American Affairs, a U.S.A. Government Agency.*

## REPORT OF LEAGUE MEETINGS IN BOSTON

October 10, 1951

The 55th Annual Convention of the National League of Nursing Education was held at the Statler Hotel in Boston, Massachusetts on May 7-11, 1951.

At a meeting of the League Board of Directors which took place the preceding Sunday, an overall review of the activities of the League during the past year was given. These included:

1. A critical evaluation of the forms which were set up rather hastily by the Joint Committee of the National Nursing Organizations for the survey of school of nursing programs.
2. The appointment of a committee to compile new forms for the above purpose.
3. A joint meeting of the League Board with the Board of the National Nursing Accreditation Service.

In making plans for the future visitation of schools of nursing, it was suggested that 25 individuals be selected from hospitals and universities and given adequate preparation for the task of surveying schools of nursing. Research was emphasized throughout the Board meeting.

On Monday, May 7, the convention began, with a program on "Nursing Education for Nursing Service." Later a round table discussion on "The Contribution of the Professional Nurse to the Community" was offered for the special benefit of nursing students. A student presided and men and women outstanding in their respective fields participated. These experts were:

- Mr. George Meckechne, Dean of the College of Physical Education at Boston University
- The Rev. James Moynahan, S.J., Associate Professor of Psychology at Boston College
- Mrs. Philip Eiseman, a citizen of Cambridge, Massachusetts, and
- Mrs. Evangeline Morris, Director of Nursing at Simmons College, Boston

It was indeed delightful to see the students participate so actively in the floor discussion that followed. Their spontaneity and easy observance of parliamentary procedure were stimulating to the older individuals.

The following day was devoted to "Science at Work in Nursing." Findings of a study along these lines indicated the need to study behavior reactions in a total situation as well as to integrate the various sciences in nursing. The study further demonstrated that:

1. Nursing is a profession.
2. It must help in solving social problems.
3. It must prepare workers to work cooperatively with other groups.
4. It must build its educational programs to prepare the nurse to understand man and contribute to sound behavior patterns in man.

The study was undertaken to select from the wealth of material available the essential sciences basic to school of nursing programs and to organize this material into an integrated course, thereby eliminating repetition.

At another session of the convention, Margaret Arnstein, Chief of the Division of Nursing Resources of the Federal Security Agency, U.S.P.H.S., Washington, D.C., spoke on "What

Is Society's Need for Nursing Service?" She included material gathered in surveys made by 27 States and the Territory of Hawaii. All surveys indicated professional nursing shortages, especially in mental institutions and tuberculosis sanatoria and in the field of public health nursing. They also brought out the need for additional preparation of personnel in many areas of nursing. These surveys utilized data already available locally, information furnished by hospital associations, and nursing standards presently accepted by nursing organizations.

At a meeting, the theme of which was "Preparing for Quality Nursing," Ruth Farrisey of the Massachusetts General Hospital presented a panel which attempted to show the "best possible means of teaching the student the most efficacious methods of using the Referral Plan both within and without the hospital." Miss Farrisey listed a number of teaching implications in the use of referral plans. Some of them were:

1. It has been of great value in showing the need for joint participation in patient care planning . . . it brings in the head nurse, the doctor, the social worker, the dietitian, etc.
2. It presents to student nurses and other nursing personnel the idea that everyone on the hospital team has the opportunity to initiate referrals.
3. It is a tool for better personnel relationships.
4. It is an aid to better service to patients.

This session closed with a tour of the Bullfinch Amphitheatre where the first general anesthetic was administered, to a man having an operation on his jaw. An historical note of this procedure is engraved on the walls. The amphitheatre is still used by medical students for lectures and demonstrations.

SISTER M. LAURINE, O.S.F.,

*Nursing Arts Instructor, St. Francis Hospital,  
Delegate from Hawaii to LNE Convention.*

## HOBBY CORNER

My hobby is knitting, and crocheting, any and everything from baby booties, up to bedspreads, rugs, and afghans. I find that when I am very tired, knitting or crocheting relaxes me a great deal and I feel very much rested after only a very few moments. Then too, it is so very fascinating to watch the pattern materialize, and the article that I am knitting on grow until it is completed. I hope that the above will be of interest enough to place in the hobby corner, and if so, that someone else will be interested in taking up the same thing.

MARGARET M. WILKINSON  
*Staff, Queen's Hospital*



## X-RAYS FOR ST. FRANCIS' ADMISSIONS

SISTER MAUREEN\*

Beginning October 1, 1951, St. Francis Hospital adopted the tuberculosis survey program whereby miniature chest films are taken on all patients admitted (over the age of 10 years) and on all personnel without charge to them.

The Bureau of Tuberculosis of the Department of Health interested the Tuberculosis Association in the installation at St. Francis Hospital of a photo-roentgen unit for this purpose. It is hoped that cooperation will promote a high percentage of x-rays in the groups that may profit by the program.

\* Assistant Administrator at St. Francis Hospital.

## ALOHA

Since I will have left the Territory before the next issue of the INTER-ISLAND BULLETIN appears, I am taking this opportunity to tell the members of the association how much I have enjoyed working with them, and how I have appreciated their friendliness and cooperation. This has been true not only in my brief tenure as editor but in nursing activities through the years.

My warm aloha to you all, and no doubt I'll be back working on committees with you some day.

LAURA DRAPER,  
*Editor.*

*It's TIME to consider . . . TIME-SAVING*

**LIEBEL-FLARSHEIM**

**DIATHERMY**

Yes, time is running out. F.C.C. restrictions on diathermy frequency and harmonics will be in full effect June 30, 1952.

**L-F MODEL SW 660** short wave diathermy meets all F.C.C. requirements and will pay for itself in the time it saves in YOUR office.

*Distributed by*

**Wadsworth's**  
PHOTO-MATERIALS  
SINCE 1925

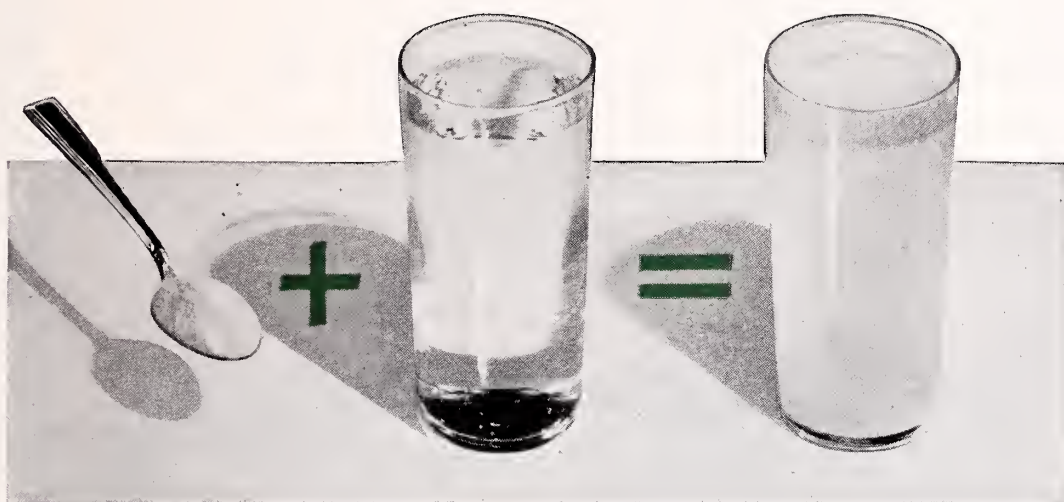
1158 Fort St., Honolulu  
Phone 5-6040 or 5-6045

Please send me further information on the  
L-F SW 660 Diathermy unit.

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

# Normohydration FOR BOWEL REGULATION



**T**ypically, the constipated stool is dehydrated, whereas the diarrheal stool or that induced by salines and irritants is hyperhydrated, containing free water.

When Metamucil is employed for the management of constipation, it is mixed in a full glass of cool liquid. The ingested liquid containing the mucilloid promotes normohydration.

**METAMUCIL<sup>®</sup>** is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. G. D. Searle & Co., Chicago 80, Illinois.



**SEARLE** RESEARCH IN THE SERVICE OF MEDICINE





# BELIEVE IN YOURSELF!

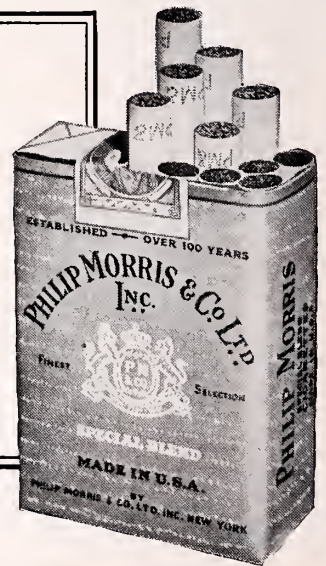
Doctor, you probably have read a great deal of cigarette advertising with all sorts of claims.

So we suggest: make this simple test...

Take a PHILIP MORRIS — and *any* other cigarette. Then,

1. Light up either one. Take a puff — don't inhale — and s-l-o-w-l-y let the smoke come through your nose.

2. Now do exactly the same thing with the other cigarette.



*Then, Doctor, BELIEVE IN YOURSELF!*

## PHILIP MORRIS

Philip Morris & Co. Ltd., Inc.  
100 Park Avenue, New York 17, N. Y.

# *Mobilizing Fluid* IN CARDIAC EDEMA

"Mercurial diuretics are a most effective means of mobilizing fluid in patients with cardiac edema. The use of these agents may augment greatly the effect of sodium restriction and digitalis administration."<sup>1</sup>

Salyrgan-Theophylline—a combination of a potent mercurial diuretic with theophylline—is effective orally in certain cases as well as parenterally. It is extensively used in the treatment of cardiac and cardiorenal edema, dropsy of nephrosis, and ascites of hepatic cirrhosis.

1. Tharn, G. W., and Tyler, F. H.: *Med. Clin. North America*, 31:1081, Sept. 1947.

Salyrgan, trademark reg. U. S. & Canada



*Salyrgan*®  
THEOPHYLLINE

BRAND OF MERSALYL AND THEOPHYLLINE

Ampuls (1 and 2 cc.)—Ampins (1 cc.)—Tablets

*Winthrop Stearns* INC.  
NEW YORK 18, N. Y. WINDSOR, ONT.



**"Nowhere in medicine are more dramatic therapeutic effects obtained than those which follow estrogen therapy in the girl who has failed to develop sexually. A daily dose of 2.5 to 3.75 mg. of 'Premarin' given in a cyclic fashion for several months may bring about striking adolescent changes in these individuals."\***

\*  
Hamblen, E. C.: Some Aspects  
of Sex Endocrinology  
in General Practice,  
North Carolina M. J.  
7:533 (Oct.) 1946.



**"PREMARIN"**

*Estrogenic  
Substances  
(water-soluble)  
also known as  
Conjugated  
Estrogens  
(equine).*

"Premarin"—a naturally occurring conjugated estrogen—long a choice of physicians treating the climacteric—has been earning further clinical acclaim as replacement therapy in hypogenitalism.

In the treatment of hypogenitalism, the aim of "Premarin" therapy is to develop the reproductive and accessory sex organs to a state compatible with normal function.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

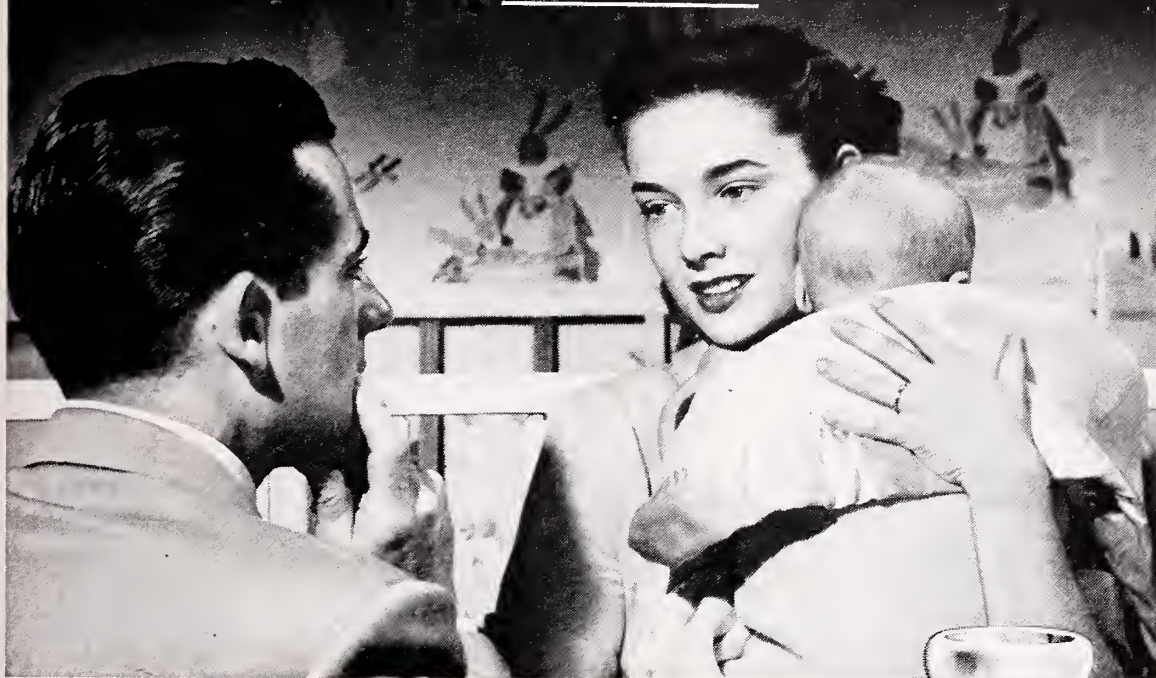
"Premarin" contains estrone sulfate plus the sulfates of equilin, equilenin,  $\beta$ -estradiol and  $\beta$ -dihydroequilenin. Other  $\alpha$ - and  $\beta$ -estrogenic "diols" are also present in varying amounts as water-soluble conjugates.



**Ayerst, McKenna & Harrison Limited**  
22 East 40th Street, New York 16, New York

5005 R

**"My doctor just said 'evaporated milk'  
—I wonder which brand he meant?"**



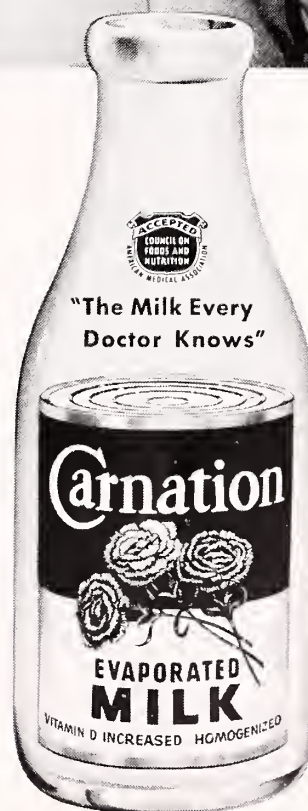
***There are Several Hundred Brands...***

**BUT ONLY ONE CARNATION!**

UNFAMILIAR brands of evaporated milk *may* be safe and uniform...but you're *sure* when you say Carnation. For generations, Carnation with water and carbohydrates has been recommended for infant feeding by America's leading doctors and hospitals.

And Carnation protects your recommendation with rigid standards of safety, uniformity and nutritional value. Every drop is processed with "*prescription accuracy*" in Carnation's *own* plants. From cow to can, Carnation Milk is constantly under Carnation's *own* supervision and inspection to make sure that it meets the exacting requirements of the medical profession.

Doctors know that Carnation is *one* evaporated milk that is readily available everywhere...*one* brand that is *always the same* wherever mothers buy it. No wonder 8 out of 10 mothers who use Carnation say, "*My doctor recommended it.*" It is the milk you can prescribe *by name* with complete confidence.



**DON'T SAY "EVAPORATED MILK"— SAY**

**Carnation**

**"from Contented Cows"**



# Cortone®

## Safety in the Prolonged Control of RHEUMATOID ARTHRITIS



Successful clinical experience with CORTONE in many *large series* of patients reveals the safety of this product in individualized dosage. One investigator notes: "We have not been impressed by the severity or frequency of side-effects . . . The side-effects due to excessive adrenal cortical hormone disappeared when the hormonal agent was discontinued."

Norcross, B. M., *N. Y. State J. Med.* 51: 2356, Oct. 15, 1951.

CORTONE is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone. This substance was first made available to the world by Merck research and production.

**Cortone®**  
ACETATE  
(CORTISONE Acetate Merck)

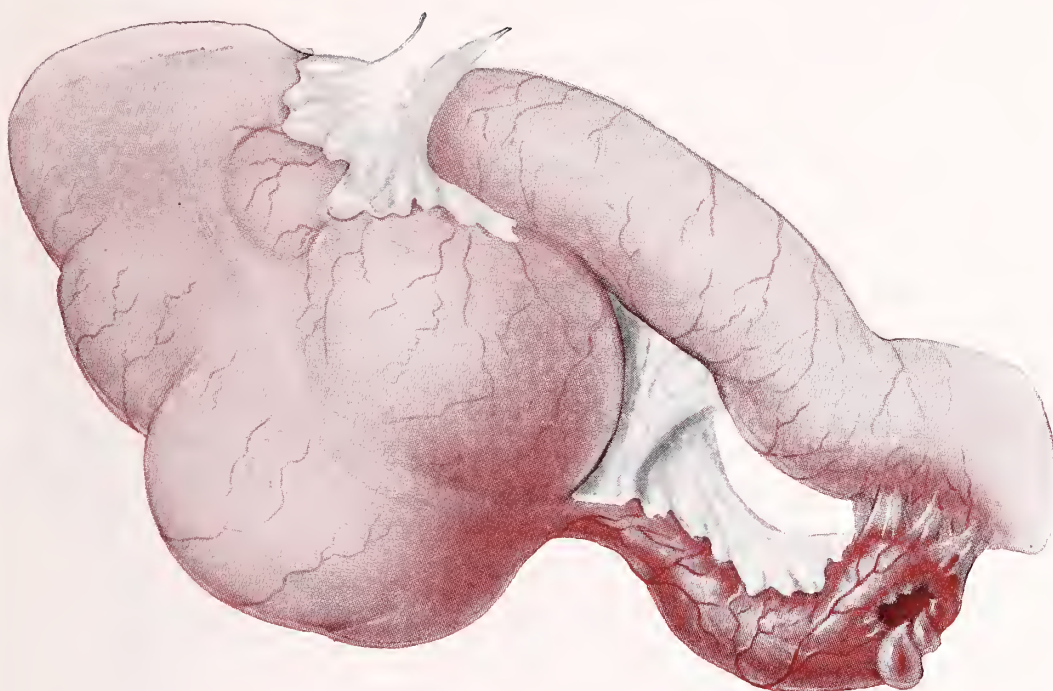


**MERCK & CO., INC.**

*Manufacturing Chemists*

RAHWAY, NEW JERSEY

*In Canada: MERCK & CO. Limited—Montreal*



*in peritonitis*

A "most . . . effective agent to date  
in our hands is terramycin,  
of which we administer 1 gram  
intravenously every 12 hours."

*Schaeffer, J. R., and Pulaski, E. J.:  
U. S. Armed Forces M. J. 1:1447 (Dec.) 1950.*

CRYSTALLINE TERRAMYCIN HYDROCHLORIDE  
is available for the control of  
a wide range of infectious disease as  
*Capsules, Elixir, Oral Drops,  
Intravenous, Ophthalmic Ointment  
and Ophthalmic Solution.*

ANTIBIOTIC DIVISION



CHAS. PFIZER & CO., INC., Brooklyn 6, N. Y.

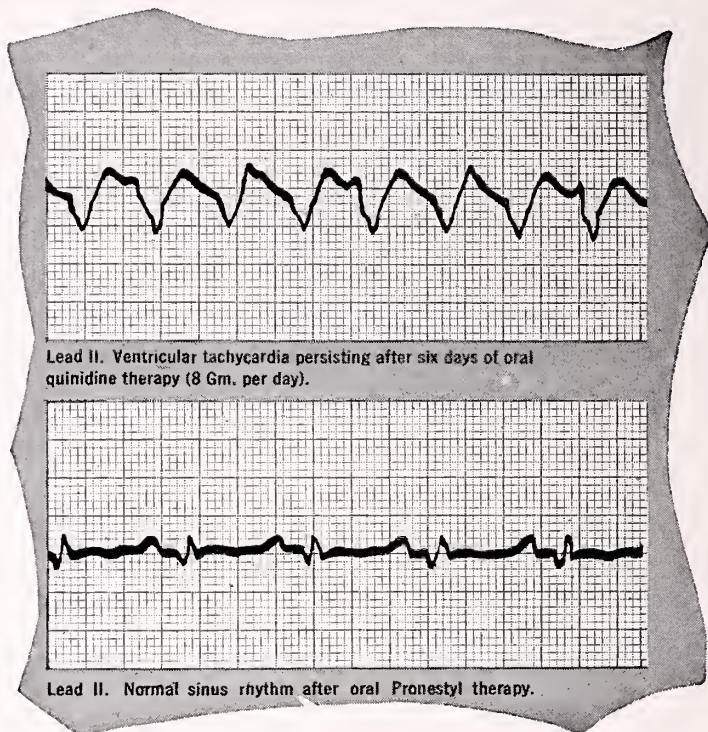


a new drug . . .

*for the treatment of ventricular arrhythmias*

# PRONESTYL *Hydrochloride*

*Squibb Procaine Amide Hydrochloride*



Oral administration of Pronestyl is indicated in ventricular tachycardia and runs of ventricular extrasystoles. Intravenous administration is sometimes used in ventricular tachycardia and to correct ventricular arrhythmias during anesthesia. For detailed information on dosage and administration, write for literature or ask your Squibb Professional Service Representative.

PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.  
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

**SQUIBB** MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.

# ISLAND SPORTSWEAR

...profits in prints

*Hawaii today is working to build new industries to aid in expanding the islands' economy. This series of advertisements calls attention to these forward steps . . . and to their promise for Hawaii's future.*

One week each year Oahu takes time out to pay tribute to its traditions. It celebrates its annual Aloha Week, and, as part of the celebration, stages what is probably the nation's biggest style show—*island-wide* and all week long.

The entire community models fashions for the occasion . . . Aloha shirts, muumuus, holokus, holomuus. They're the islands unofficial but traditional "uniforms," and they fill as big a role in the year 'round economy as they do in the week of parades and pageants.

The casual, comfortable island clothes will this year bring in approximately \$5,000,000 on the wholesale market, more than half of it from export trade. The rest are island dollars, which otherwise would have gone to the mainland. Two years ago the industry's value was only half that amount; its market almost entirely in the islands. Today sportswear is one of Hawaii's top six exports and the industry has solid hopes of doubling itself again.

In 1920, when garment manufacturing was first recognized as a growing industry, three firms employed less than 100 people to make overalls and other work clothes. Today 32 firms employ more than 1,000 people and their products range from swimsuits to sarongs. Patterns are designed in Honolulu, then sent to the mainland where huge rotary presses print miles of fabric in up to half a dozen colors. The cloth is shipped to the islands for a production-line process of cutting, sewing and pressing, then finished garments go to market—all around the world.

Hawaii, putting into it's sportswear all the colors of a Manoa rainbow, has found for itself a substantial pot of gold . . . another growing industry for a growing community.



## FREE BOOKLET

A brief survey of Hawaii's growing sportswear industry has been published to show how island firms can build both local and export markets for their production. For a free copy, write The Hawaiian Electric Co., P. O. Box 2750, Honolulu.

*The development of new industries requires individual initiative and community cooperation. In keeping with this progressive spirit of growth, The Hawaiian Electric Co., Ltd., is constantly planning ahead, expanding its own facilities and equipment . . . building today for tomorrow's needs.*

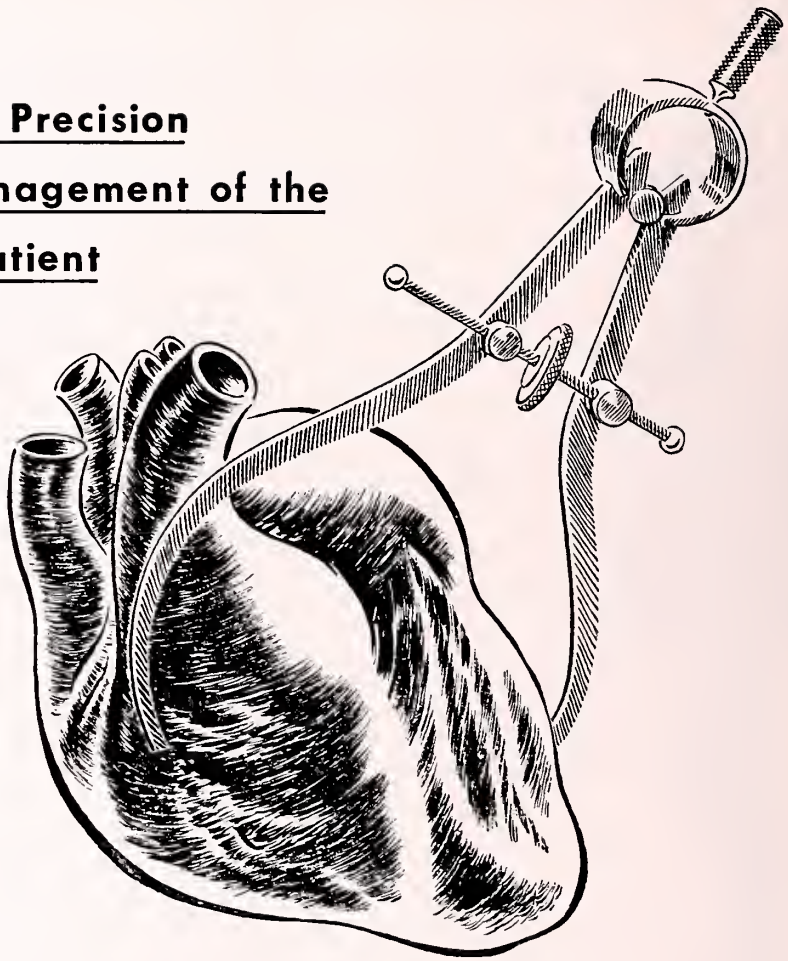
**THE HAWAIIAN ELECTRIC CO., LTD.**



**BUILDING TODAY for Tomorrow's Needs**



**To Assure Precision**  
**in the management of the**  
**cardiac patient**



**PURODIGIN offers the advantages of:**

- a crystalline product of uniform potency,
- fully active by mouth;
- supplied in graduated potencies
- to facilitate dosage to meet the needs of the individual patient.

TABLETS OF: 0.05, 0.1, 0.15 and 0.2mg.

**PURODIGIN<sup>®</sup>**  
CRYSTALLINE DIGITOXIN, WYETH



*Wyeth* Incorporated, Philadelphia 2, Pa.



*turning-point*

Under stress—burns, severe infections, surgery—when the greater need for adrenal cortical hormones may tax the patient's resources, appropriate supportive therapy may influence favorably the turning-point toward recovery.

R<sub>x</sub>

## **Upjohn Adrenal Cortex Extract**



*10 cc. and 50 cc. vials of sterile solution for subcutaneous, intramuscular or intravenous injection.*

Continuous Upjohn research in the physiology and chemistry of the adrenal gland has made available potent, standardized extracts providing *all* the natural hormones of the adrenal cortex.

*Each cc. of Upjohn Adrenal Cortex Extract contains the biological activity equivalent to 0.1 mg. of 17-hydroxycorticosterone, as standardized by the Rat Liver-Glycogen Deposition test. Alcohol 10%.*

*a product of*

**Upjohn**

**Research** *for medicine . . . produced with care . . . designed for health*

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN



## *Relationship of Stress to Autonomic Liability*

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance.<sup>1,2</sup> Such states may involve any one of the organ systems or several at one time.<sup>1,3</sup> The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vasoconstriction	Slow heart rate Vasodilatation
Functional Manifestations	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic liability:

Variable Blood Pressure  
Body Temperature Variations  
Changing pulse rate  
Deviations in B. M. R.  
Exaggerated Cold Pressure Reflex  
Oculo-Cardiac Reflex Abnormalities  
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy\*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

\*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. 6,9,10.

1. Ebaugh, F.: *Postgrad. Med.* 4: 208, 1948. 2. Wilbur, D.: *J.A.M.A.* 141: 1199, 1949. 3. Williams, E. and Carmichael, C.: *J. Nat'l. Med. Assoc.* 42: 32, 1950. 4. Goodman, L. and Gilman, A.: *The Pharmacological Basis of Therapeutics*, The Macmillan Co., 1941. 5. Katz, L. et al: *Ann. Int. Med.* 27: 261, 1947. 6. Weiss, E. et al: *Am. J. Psychiat.* 107: 264, 1950. 7. Alvarez, W.: *Chicago Med. Soc. Bulletin*, 581, 1950. 8. Rakoff, A.: *A Course in Practical Therapeutics*, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: *A Handbook of Psychiatry*, C. V. Mosby Co., 1945. 10. Harris, L.: *Canad. M.A.J.* 58: 251, 1948.

## INDEX TO ADVERTISERS

	PAGE
Abbott Laboratories .....	140
Ayerst, McKenna & Harrison.....	182
Borden Company .....	144
Carnation Company .....	183
Dairymen's Association, Ltd.....	138
Don Baxter, Inc. ....	141
Eli Lilly & Company.....	129, Insert
Ethicon Suture Laboratories, Inc.....	Insert
Hawaiian Electric Company.....	187
Home Insurance Company.....	137
Hotel Import Company.....	142
Lederle Laboratories .....	139
Matson Lines .....	137
McArthur & Summers.....	Insert
Mead Johnson & Company.....	192
Merck & Company, Inc.....	184
Parke Davis & Company.....	130, 131
Pet Milk Company.....	132
Chas. Pfizer & Company.....	133, 185
Philip Morris & Co., Ltd., Inc.....	180
Sandoz Pharmaceuticals .....	190
Schering Corporation .....	191
Schieffelin & Company .....	167
Schuman Carriage Company.....	135
Searle & Company.....	179
Sharp & Dohme.....	136
E. R. Squibb & Sons.....	186
Upjohn .....	189
Wadsworth's .....	178
Wander Company.....	134
Winthrop-Stearns, Inc. ....	181
Wyeth, Inc. ....	188

**Sandoz  
Pharmaceuticals**

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, NEW YORK



## An Unsurpassed Estrogen Therapy

Small dosage makes ESTINYL inimitable among orally effective estrogens. As little as *two hundredths of a milligram daily* relieves menopausal symptoms and produces a sense of well-being obtainable only with larger doses of other estrogens.

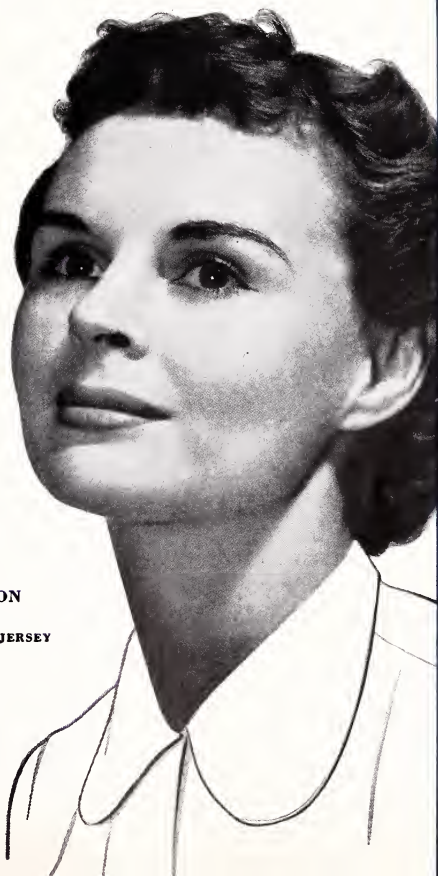
# ESTINYL®

(ethinyl estradiol-Schering)

Available for treatment of menopause and other estrogen deficiency states, in tablets of 0.02, 0.05 and 0.5 mg.

*Schering* CORPORATION

BLOOMFIELD • NEW JERSEY



ESTINYL





# D

ispels the ever-lurking shadow

Even in America today, surveys of certain groups have revealed a disturbing incidence of rickets.

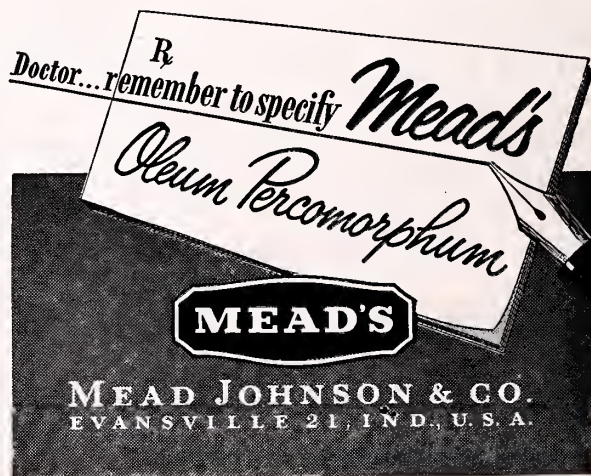
Physicians realize the danger of this ever-lurking shadow, and the need for *regular, reliable protection*.

They know, too, that for most patients this protection must be economical.

That is why, *for seventeen years*, they have written so many millions of prescriptions for Mead's Oleum Percomorphum.

No other vitamin product has ever had such a background of clinical evidence.

And rarely does the physician have such *assurance* at the tip of his pen.



# AWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

MARCH-APRIL, 1952

APR 21 1952

NUMBER 4

LIBRARY

RHEUMATIC HEART DISEASE IN INDUCTEES Charles L. Leedham and Larry A. Smith.....	211
A DENTAL SURVEY OF INDUCTEES IN HAWAII Robert J. Fanning.....	214
DENTAL CARIES IN STUDENTS OF JAPANESE ANCESTRY Carey D. Miller, Agnes C. Bickerton and Gerald L. Parke.....	216
ADMISSION X-RAY PROGRAM IN A GENERAL HOSPITAL Elizabeth H. Middleton, Adele P. Schlosser and Marion C. Burns.....	221
FEATURES .....	225
INTER-ISLAND NURSES' BULLETIN.....	241



## *"...what about Lilly advertising?"*

"You have never seen a product advertisement prepared by Eli Lilly and Company which was intended for the public. Why? Because they believe that if they were to do so with their particular type of products, they would tend to encourage improper self-treatment and interfere with your prescriptions for scientific medication."

*Lilly*

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.



# Adrenalin<sup>®</sup>

(epinephrine, Parke-Davis)

*the first*

hormone to be isolated in pure  
crystalline form



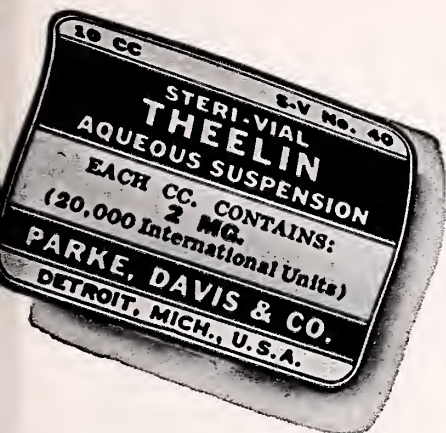
*the first*

American antihistaminic

# Benadryl<sup>®</sup> HYDROCHLORIDE

(diphenhydramine hydrochloride, Parke-Davis)





# Theelin

(ketohydroxyestratriene, Parke-Davis)

*the first*  
crystalline estrogenic substance



# Chloromycetin®

(chloramphenicol, Parke-Davis)

*the first*  
and only antibiotic synthesized  
on a practical scale

The Parke-Davis label, known and relied on the world  
over, is a respected symbol in research, in clinical  
investigation, and in quality production.

*Parke, Davis & Company*  
DETROIT, MICHIGAN



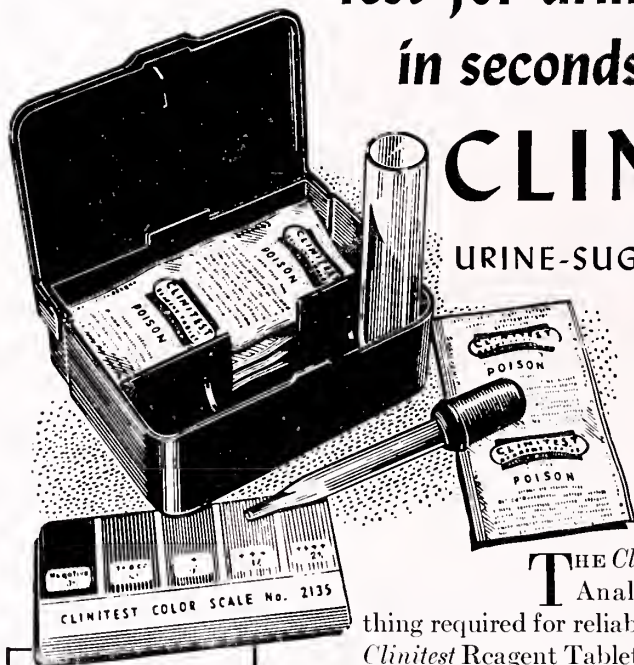
Test for urine-sugar  
in seconds...with New

**CLINITEST**

(BRAND)

URINE-SUGAR ANALYSIS TEST

UNIVERSAL  
MODEL



**T**HE *Clinitest* (Brand) Urine-sugar Analysis Set contains everything required for reliable urine-sugar testing. The *Clinitest* Reagent Tablets (Sealed in Foil), supplied with this Set, present a copper reduction test with all reagents compressed into a single tablet. No external heating is required as each tablet, on dissolving, generates the necessary heat.

To perform a test, simply drop one *Clinitest* Reagent Tablet into test tube containing proper amount of diluted urine. Allow time for reaction, then compare with color scale. A rapid, convenient and reliable test for urine-sugar that is ideal for doctor, patient and laboratory.

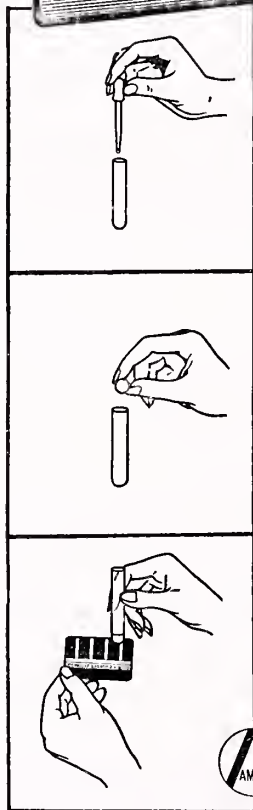
Each Set contains 10 *Clinitest* Reagent Tablets individually sealed in foil. Tablets may be replaced with either additional tablets sealed in foil from No. 2157, boxes of 24, or with No. 2107 bottles of 36. Contact our representative for literature.

**HOTEL IMPORT COMPANY**

P. O. BOX 2630

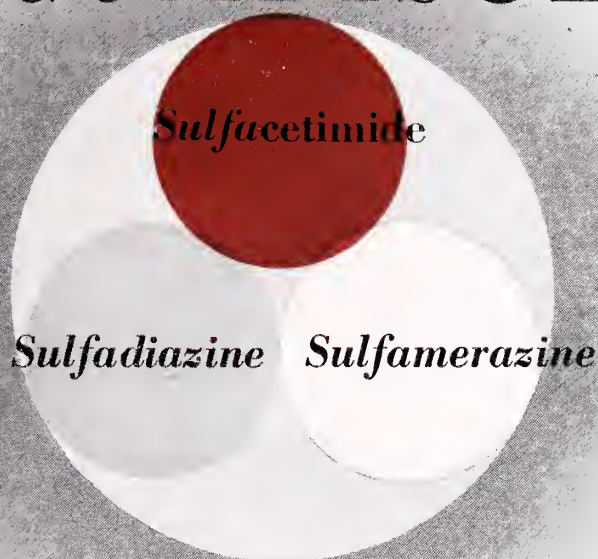
HONOLULU 3, HAWAII

**AMES COMPANY, INC.**  
Elkhart, Indiana, U. S. A.



*sulfonamide Mixture Therapy At Its Best*

# TRICOMBISUL



For greater clinical safety plus the advantages of more rapid absorption, better tissue distribution and faster therapeutic effect.

**TRICOMBISUL Tablets**, 0.5 Gm. total sulfonamides, each tablet containing 0.166 Gm. of *sulfacetimide*, sulfadiazine and sulfamerazine.

**TRICOMBISUL Liquid**, 0.5 Gm. total sulfonamides (0.166 Gm. each of *sulfacetimide* [solubilized], sulfadiazine and sulfamerazine) per teaspoonful (4 cc.).

\*T.M.

*Schering* CORPORATION • BLOOMFIELD, NEW JERSEY

TRICOMBISUL





**"PREMARIN"**®

Highly effective • Well tolerated • Imparts a feeling of well-being

**"PREMARIN"**

Most menopausal patients  
experience striking relief  
of symptoms with "Premarin."

**"PREMARIN"**

Estrogenic Substances (water-soluble)

**"PREMARIN"**



also known as Conjugated Estrogens (equine)

**"PREMARIN"**





## How this Great Champion Helps Protect Your Recommendation of Carnation

**CARNATION HOMESTEAD DAISY MADCAP** is her name. She's one of the many world champion cattle bred at the famous Carnation farms near Seattle. Cattle from these fine, prize-winning bloodlines are shipped to dairy farmers throughout the country to improve the quality of Carnation's local milk supply...and thus help protect your recommendation of Carnation.

### Only Carnation Gives Your Recommendation this 5-WAY PROTECTION

1. Carnation accepts only high quality milk for processing. Carnation Field Men regularly check local farmers' herds, sanitary conditions and equipment—reject milk if it fails to meet Carnation's high standards.
2. Carnation processes ALL milk sold under the Carnation label. From cow to can it is processed with prescription accuracy in Carnation's own plants under its own supervision.
3. Carnation quality control continues even AFTER the milk leaves the plant. To be sure of freshness and highest quality, Carnation salesmen use a special code control in making frequent inspection of dealers' stocks.
4. Carnation Milk is everywhere. Mothers get Carnation Milk in virtually every grocery store in every town throughout America.
5. Cattle bred from champions such as the one pictured above are distributed to local dairy farmers to improve the quality of the milk supplied to Carnation processing plants.



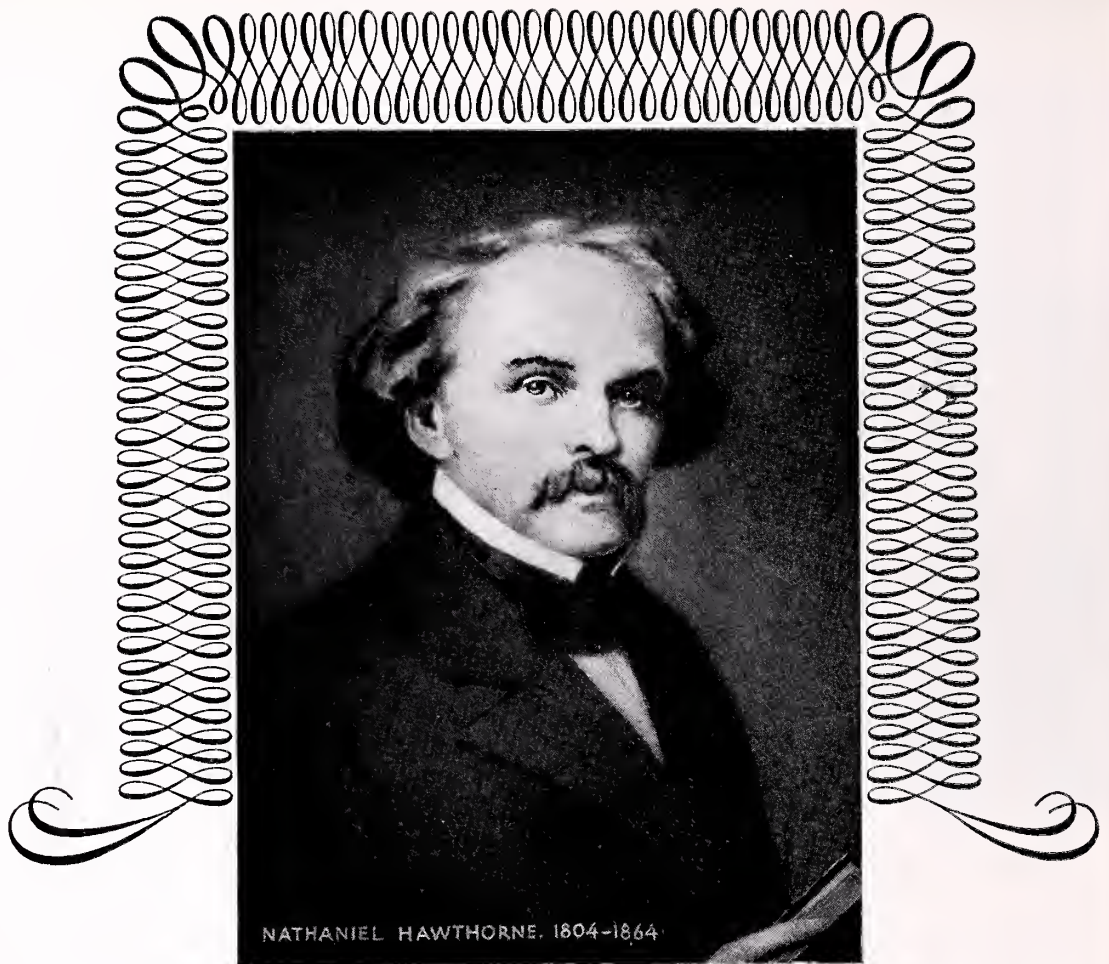
**DOUBLE-RICH** in the food values of whole milk.  
**FORTIFIED** with 400 units of Vitamin D per pint.  
**HEAT-REFINED** for easier digestibility.  
**STERILIZED** in the sealed can for complete safety.

"The Milk Every Doctor Knows"



"from Contented Cows"





## *Psychoneurotics of Genius*

Hawthorne, distinguished American novelist, is said to have been afflicted with a psychoneurosis from early childhood. His quiet life, wholly detached from the major activities of the times, was largely given over to brooding solitude.

The majority of psychoneurotics have no serious mental illness, but display merely an emotional imbalance which often can be greatly improved by appropriate psychotherapeutic and sedative management. In the treatment of psychoneurosis, particularly agitated, depressed and anxiety states, Mebaral is especially useful when tranquillity with minimal hypnotic action is desired. Sedative dose: Adults, from 32 mg. to 0.1 Gm. ( $\frac{1}{2}$  to  $1\frac{1}{2}$  grains) three or four times daily. Children, from 16 to 32 mg. ( $\frac{1}{4}$  to  $\frac{1}{2}$  grain) three or four times daily. Supplied in tablets of 32 mg., 0.1 Gm. and 0.2 Gm.

# MEBARAL<sup>®</sup>

*Brand of Mephobarbital*

**Tasteless SEDATIVE AND ANTIEPILEPTIC**  
Little or No Drowsiness.

**WINTHROP-STEARN'S INC. • NEW YORK 18, N. Y. • WINDSOR, ONT.**

Mebaral, trademark reg. U. S. & Canada



## All Children Can Benefit from *this* Protective Hot Drink at Breakfast

In its widely distributed leaflet No. 268, "Eat a Good Breakfast," the U. S. Dept. of Agriculture states: "Summer or winter, there's something hot, as a rule, in a good breakfast.... Something hot is cheering and tones up the whole digestive route."

The problem of encouraging children to eat an adequately protective breakfast finds easier solution when Ovaltine in hot milk is recommended as a breakfast beverage. Many children clamor for a hot drink at the morning meal, and hot Ovaltine is the right kind of drink to recommend.

A cup of hot Ovaltine makes an excellent contribution of virtually all essential nutrients, adding substantially to the nutritional start for the day. It also serves in a gustatory capacity by enhancing the appeal of breakfast and making other foods more inviting.

The nutrient contribution made by a cup of Ovaltine is apparent from the table below. Note the wealth of essentials added to the nutritional intake by making the simple recommendation of adding a cup of hot Ovaltine to the child's breakfast.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILLINOIS



### Ovaltine

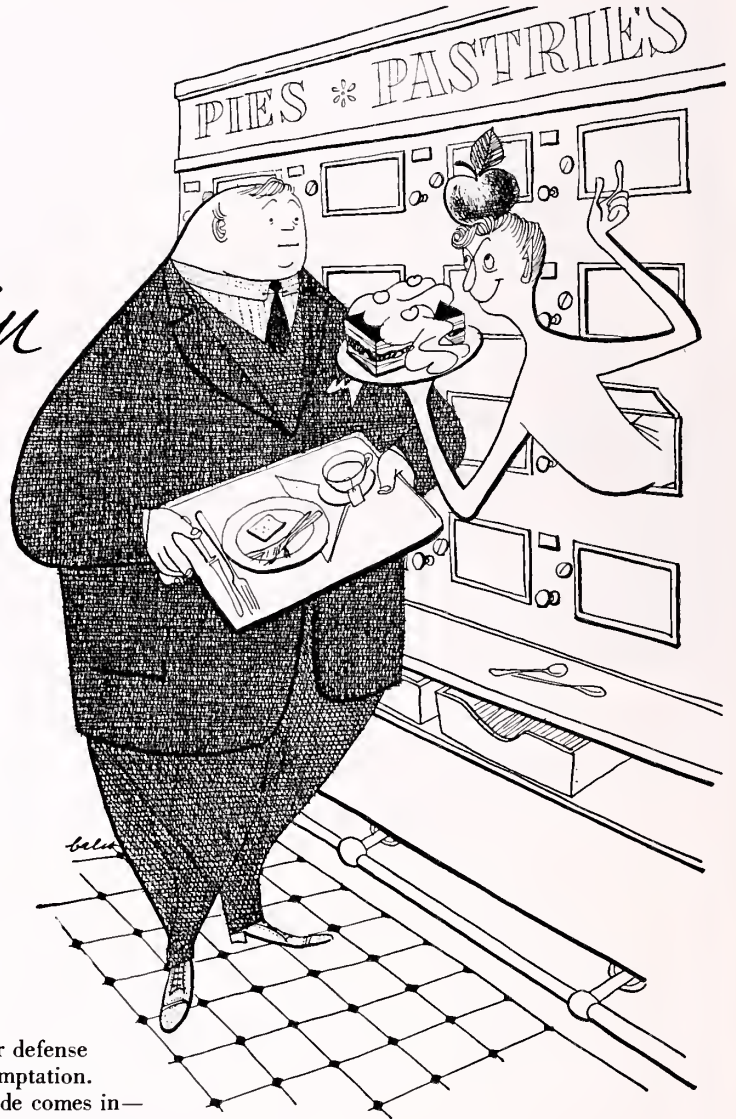
Here are the nutrients that a cupful of hot Ovaltine, made of  
½ oz. of Ovaltine and 8 fl. oz. of whole milk,\* provides:

PROTEIN . . . . .	10.5 Gm.	IRON . . . . .	4 mg.	NIACIN . . . . .	2.3 mg.
FAT . . . . .	10.5 Gm.	COPPER . . . . .	0.2 mg.	VITAMIN C . . . . .	10 mg.
CARBOHYDRATE . . . . .	22 Gm.	VITAMIN A . . . . .	1000 I.U.	VITAMIN D . . . . .	140 I.U.
CALCIUM . . . . .	370 mg.	VITAMIN B <sub>1</sub> . . . . .	0.39 mg.	CALORIES . . . . .	225
PHOSPHORUS . . . . .	315 mg.	RIBOFLAVIN . . . . .	0.7 mg.		

\*Based on average reported values for milk.



**when  
temptation  
pops  
up  
everywhere**



**W**ILL-POWER alone is a poor defense against the constant prodding of temptation. That's where DESOXYN Hydrochloride comes in—curbing the appetite, uplifting the patient's morale. Weight for weight, DESOXYN is more potent than other sympathomimetic amines so that *smaller doses* can produce the desired anorexia with a *minimum of side-effects*. One 2.5-mg. or 5-mg. tablet before breakfast and another about an hour before lunch are usually sufficient. In addition, DESOXYN has a *quicker action, longer effect*.

DESOXYN is equally effective as a valuable adjunct in depressive states associated with the menopause, prolonged illness and convalescence as well as in the treatment of narcolepsy and for adjunctive therapy in alcoholism. All pharmacies have DESOXYN in 2.5-mg. and 5-mg. tablets, in elixir form and in 1-cc. ampoules.

**Abbott**

PRESCRIBE  
**Desoxyn**<sup>®</sup>  
*hydrochloride*  
(METHAMPHETAMINE HYDROCHLORIDE, ABBOTT)

SMALLER  
DOSAGE

QUICKER  
ACTION

LONGER  
EFFECT

MINIMAL  
SIDE-EFFECTS

# Terramycin



## *intravenous*

Indicated for use in all infections of such severity that intravenous injection is the preferred route, Crystalline Terramycin Hydrochloride Intravenous provides a rapid acting form for the attainment of immediate high serum concentrations. Recommended when oral therapy is not feasible, in severe fulminating or necrotizing infections, in surgical prophylaxis in selected cases, and in peritonitis. For hospital use only.

*Supplied* | 10 cc. vial, 250 mg.;  
20 cc. vial, 500 mg.

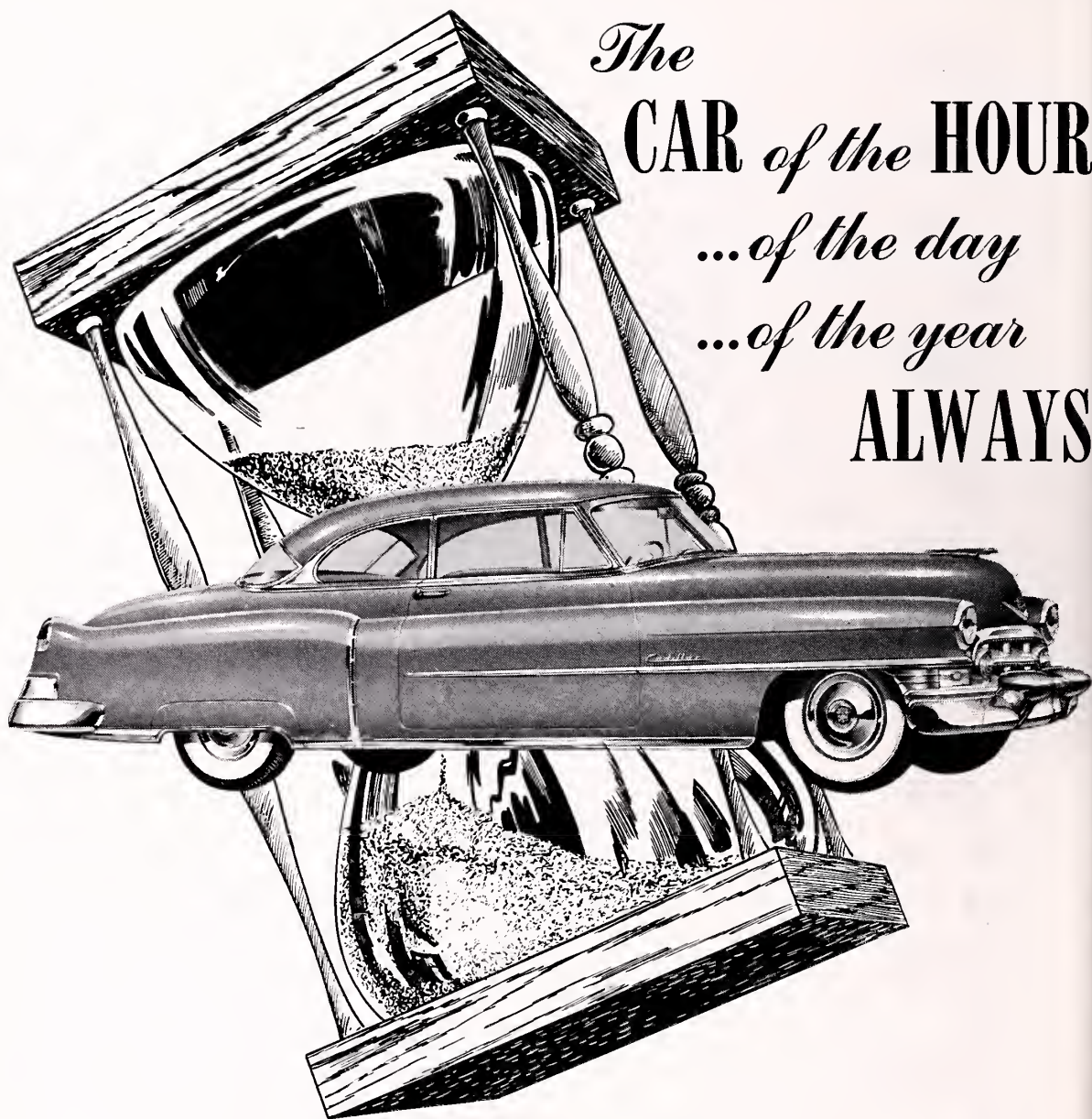
Terramycin is also available as *Capsules, Elixir, Oral Drops, Ophthalmic Ointment, Ophthalmic Solution.*

ANTIBIOTIC DIVISION



CHAS. PFIZER & CO., INC., Brooklyn 6, N. Y.





*The*  
**CAR of the HOUR**  
*...of the day*  
*...of the year*  
**ALWAYS**

*Cadillac*

FOR 1952

OPEN THURSDAYS TILL 9:00 P.M. SATURDAYS TILL 4:00 P.M.



**SCHUMAN CARRIAGE COMPANY**

Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU



# Ideal Infant Feeding Formula



## S-M-A is a complete formula.

Unmatched in similarity to healthy mother's milk, S-M-A provides all essential food elements, including vitamins and minerals well in excess of recommended daily allowances.

## S-M-A is an economical formula.

Only water need be added. Since the addition of nutritive elements is unnecessary, *the initial cost is the whole cost.* And the whole cost of the complete S-M-A formula is *less than 1¢ per ounce.*

**S-M-A** Liquid

**S-M-A** Powder



*Wyeth* Incorporated, Philadelphia 2, Pa.





Anyone for shuffleboard?  
... or do you like to watch  
the miniature ponies run?



Care for a card game ...  
bridge, canasta, cribbage?  
Game Room always open



The outdoor pool for an  
afternoon plunge ... come  
on in, the water's fine



How about a movie after  
dinner, or a musicale?  
Just walk in ... it's free

# LURLINE

Here's the sauce on your  
sundae, the gravy on your  
potatoes ... the little things  
that add up to a wonderful  
Lurline trip ... to the biggest  
bargain in mainland travel

... all this, plus  
famously fine food  
luxurious stateroom  
your transportation  
is included in your fare

as little as \$260 round trip (plus tax)

**Matson Lines** 1021 Bishop Street  
2347 Kolakaua Avenue  
Phone 50945

OR SEE ANY AUTHORIZED TRAVEL AGENT



Dancing on the Veranda,  
a night club at sea ...  
with no cover charge



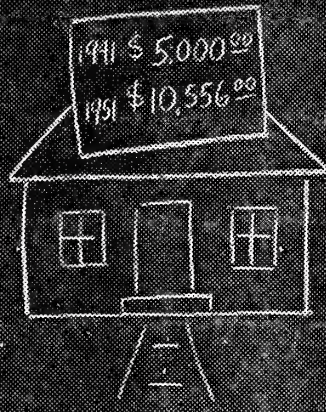
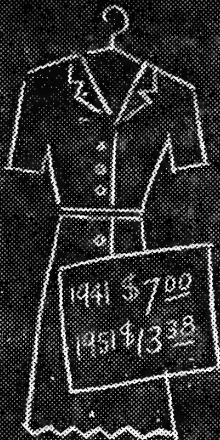
Afternoon tea on deck  
a chance to stretch out,  
take a relaxing snooze



Like Icebox raiding?  
the chef has a midnight  
snack all ready for you



Like living island style?  
Pitch in when a picnic  
lunch is served on deck



**FATHERS, TOO,  
ARE WORTH  
MORE NOW!**

*A Wise New Year  
Resolution for  
Professional Men ...*

**"I will ask a  
New England  
Mutual Career  
Life Underwriter  
to appraise my  
Insurance Estate"**

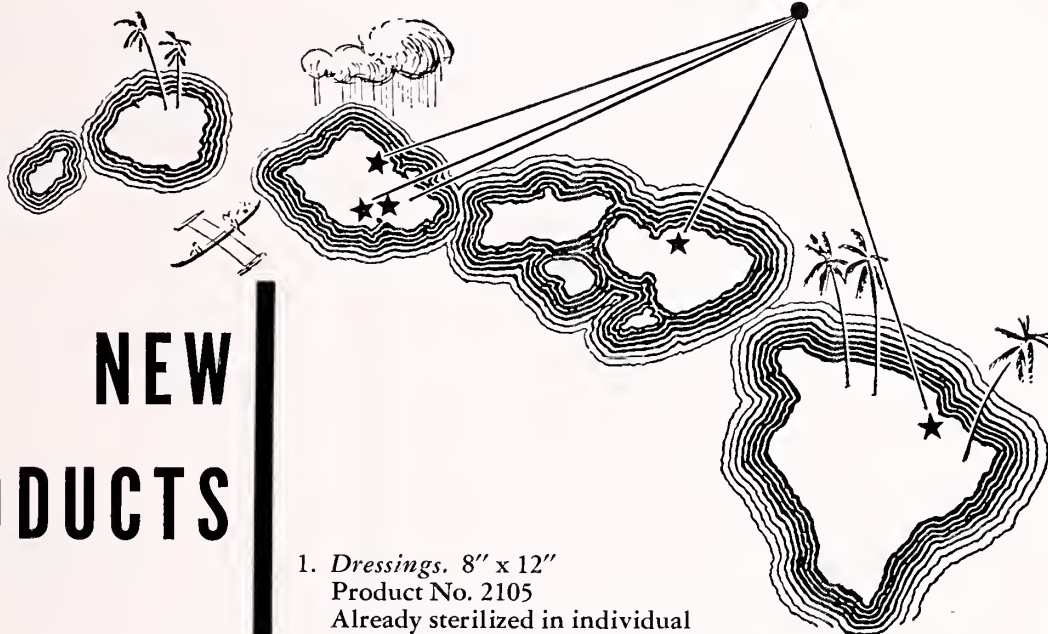
Telephone 6-3521

**Home Insurance Co.  
of Hawaii, Ltd.**

*Life Department*  
GENERAL AGENT



# DAVIS & GECK SUTURES



## NEW PRODUCTS

### AUREOMYCIN

1. *Dressings*. 8" x 12"  
Product No. 2105  
Already sterilized in individual aluminum foil envelopes. In each Dressing there are 320 mg. of crystalline aureomycin hydrochloride.
2. *Packing*. (Also sterilized) is available in glass jars in three sizes.  
1/2" x 24" Product No. 2102  
1" x 36" Product No. 2103  
2" x 36" Product No. 2104

### SURGALOY MESH

For Reconstructive Surgery  
#71 6" x 12" 50 x 50 Mesh per sheet \$12.50

25 yard Spools      Sizes  
100 yard Spools    6-0 to 5

### ANACAP SURGICAL SILK

1. *Greater tensile strength*—often double that of other brands.
2. *Noncapillary*—no wick-like action; no splintering.
3. *Easier to handle*—never goes limp; speeds suturing.
4. *Repeatedly sterilized*—no alteration in strength if sterilized over and over.
5. *Economical*—low initial cost; long sterilization life.

### HOTEL IMPORT COMPANY

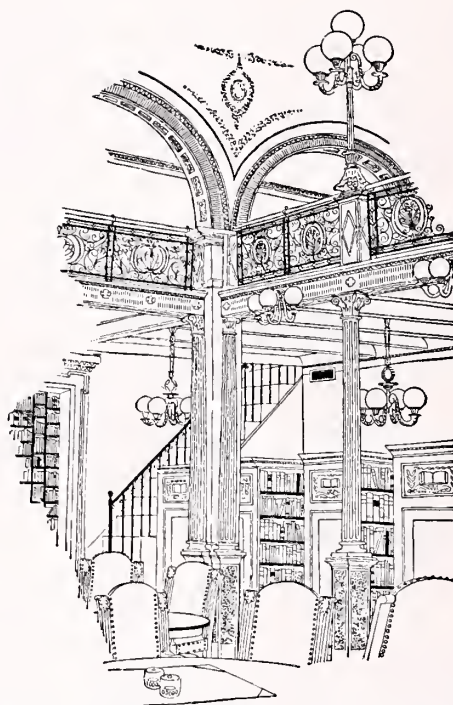
Wholesale Druggists and Hospital Purveyors

Division of the Von Hamm-Young Company, Ltd.

Cooke and Kawaiahao Streets • Phone 6-3561



*from  
among all  
antibiotics  
Pediatricians  
often choose*



# AUREOMYCIN

*Hydrochloride Crystalline*

*because...* Aureomycin may be given by the oral, or in an emergency by the intravenous, route. Aureomycin readily and rapidly diffuses into all the tissues and fluids of the body.

Aureomycin in divided small dosage has given serum levels comparable with those following one large dose.

Aureomycin is clinically effective in the control of infections of bacterial, rickettsial, and large viral origin.

Aureomycin has been reported to be effective against susceptible organisms in: Bronchiolitis • Bronchitis • Colitis • Epidemic Diarrhea • Childhood Genitourinary Infections • Laryngotracheobronchitis • Secondary Infections following Measles • Mucoviscidosis (pancreatic fibrosis) • Neonatal Infection • Otitis Media • Mastoiditis • Pertussis Pneumonia • Scarlet Fever • Secondary Invasion following Varicella

*Throughout the world, as in the United States, aureomycin is recognized as a broad spectrum antibiotic of established effectiveness.*

Capsules: 50 mg.—Bottles of 25 and 100. 250 mg.—Bottles of 16 and 100.  
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* 30 Rockefeller Plaza, New York 20, N.Y.

# HAWAII MEDICAL JOURNAL

## and INTER-ISLAND NURSES' BULLETIN

Volume 11  
Number 4

MARCH-APRIL, 1952

\$2.00 per year  
35c per copy

Published Bi-Monthly by  
**THE HAWAII TERRITORIAL MEDICAL ASSOCIATION**  
(Incorporated in 1856 under the Monarchy)

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

**THE HAWAII TERRITORIAL MEDICAL ASSOCIATION**  
1951-1952

### OFFICERS

HARRY L. ARNOLD, JR., Honolulu.....	President
R. J. MCARTHUR, Wailuku, Maui.....	President-Elect
T. DAVID WOO, Pepekeo.....	Vice-President from Hawaii County
JOHN W. DEVEREUX, Honolulu.....	Vice-President from Honolulu County
K. K. FUJII, Kapaa.....	Vice-President from Kauai County
E. T. SHIMOKAWA, Lahaina.....	Vice-President from Maui County
I. L. TILDEN, Honolulu.....	Secretary
E. K. CHUNG-HOON, Honolulu.....	Treasurer

### COMMITTEE CHAIRMEN

GROVER A. BATTEN.....	Cancer Committee
TELL NELSON.....	Health Education Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	HAWAII MEDICAL JOURNAL
F. D. NANCE.....	By-Laws Committee
JOHN W. DEVEREUX.....	Advisory Board for Woman's Auxiliary
MORTON E. BERK.....	Scientific Works Committee
ISAAC A. KAWASAKI.....	Public Service Committee
VERNE C. WAITE.....	Post-Graduate Committee
SAMUEL YEE.....	Legislative Committee


### OFFICERS — COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....T. David Woo, Pepekeo	John W. Devereux	K. K. Fujii, Kapaa	Edw. T. Shimokawa, Lahaina
<i>Vice-President</i> .....S. Kasamoto, Hilo	Wm. M. Walsh	Keith Kuhlman, Koloa	John A. Burden, Paia
<i>Secretary</i> .....Francis Wong, Hilo	Wm. S. Ito	C. H. Ishii, Lihue	Edward Kushi, Wailuku
<i>Treasurer</i> .....Richard Hata, Hilo	C. M. Burgess	C. H. Ishii, Lihue	Edward Kushi, Wailuku

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1952, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.





**2.7 to 1**

**... figures that spell  
SOUND GROWTH**

**2.7 to 1 . . . That's the ratio** of protein to fat in DRYCO, the ideal food for normal infants. It's the secret of DRYCO's success in helping infants to the right start in the important early months of life when protein demands are greatest for growth and new tissue.

DRYCO's reduced fat level minimizes digestive disturbances and helps assure tolerance and more complete utilization of feedings.

The moderate carbohydrate content of DRYCO makes it adaptable to the individual needs of every infant. Thus, the basic DRYCO formula permits the addition of the amount and type of carbohydrate needed.

In every significant respect, DRYCO digestive and nutritive characteristics parallel those of human milk. A superior quality powdered infant food, uniformly nutritious, easy to digest, vitamin enriched and specially packed to retain its original freshness, DRYCO is recommended with confidence everywhere.

In DRYCO, as in other Borden Company products, scientific control through every step of production assures the finest quality. You can place faith in the undeviating high standards of every Borden product.

*Professional information on DRYCO  
is yours by sending a card or letter to:*

**THE BORDEN COMPANY**  
Export Division  
350 Madison Avenue  
New York 17, N. Y., U. S. A.

**VITAMIN FORTIFIED**

**DRYCO**



Prop. Intellectual Res.  
Copr. 1951, Borden Co.

# Rheumatic Heart Disease in Inductees in Hawaii

CHARLES L. LEEDHAM, COLONEL, M.C., U.S.A.\*

LARRY A. SMITH, LT. COLONEL, M.C., U.S.A.F.†

HONOLULU

**R**HEUMATIC FEVER has been stated to be a disease of infrequent occurrence in tropical and sub-tropical climates.<sup>1</sup> For many years this statement has been held to be true of the Hawaiian Islands. In 1941 Doolittle and Tilden<sup>2</sup> reported a case of acute rheumatic fever which progressed through the stages so commonly encountered in the colder climates and ended in death from rheumatic pancarditis. In 1949 Berk and Hartwell<sup>3</sup> reported additional evidence of rheumatic fever in the islands in a survey of rheumatic heart disease in the hospitals of Honolulu. In 1951 Connor and Yoshina<sup>4</sup> reviewed the first two years of the rheumatic fever program at Kapiolani Children's Hospital. To this evidence that rheumatic fever is much more common in the Hawaiian Islands than previously thought, are added the following data, based on the results of physical examinations for induction into the Armed Services.

## Observations

During the period of this study, 5,419 male residents of the Hawaiian Islands, aged 19 to 25 inclusive, were examined at Tripler Army Hospital to determine their physical and mental qualifications for induction. Of this group 104 individuals (1.91%) were rejected for findings diagnosed as residuals of rheumatic fever, principally valvular heart disease. Of these 104 individuals only 23 (22.1%) gave a history of antecedent rheumatic fever. It should be noted in passing that 8 additional members of this group had prior knowledge of heart murmurs but did

not give histories which could be regarded as indicative of rheumatic fever. Table 1 shows the individual valvular lesions diagnosed.

The possible influence of racial extraction was also considered and data obtained are presented in Table 2. It should be noted that in this table racial extraction is as given by the inductee in his official statement.



COL. LEEDHAM

TABLE 1.—Distribution of Valve Lesions Diagnosed.

	HISTORY OF RHF	NO HISTORY	TOTAL
Mitral insufficiency alone.....	7	42	49
Combined mitral lesion.....	4	17	21
Mitral stenosis alone.....	..	5	5
Aortic stenosis alone.....	0	5	5
Aortic insufficiency alone.....	4	1	5
Combined aortic lesion.....	2	2	4
Mitral and aortic insufficiency.....	2	3	5
Mitral insufficiency and aortic stenosis..	1	3	4
Mitral insufficiency & combined aortic lesion.....	..	2	2
Tri-valve lesion.....	..	1	1
Pulmonary stenosis alone.....	*1	..	1
History of recent rheumatic fever, no valve lesion detected.....	2	..	2
TOTAL .....	23	81	104

\* Diagnosis confirmed by qualified cardiologist in Honolulu. Examinee was a patient of this physician.

TABLE 2.—Racial Distribution of Rejectees.

	NUMBER	% OF THOSE REJECTED	% BY RACES* OF TOTAL EXAMINED
Japanese .....	72	69.2	44.7
Chinese .....	9	8.6	8.2
Filipino .....	7	6.7	27.3
Hawaiian .....	6	5.7	3.0
Caucasian .....	6	5.7	6.8
Portuguese .....	4	3.9	0.6

\* Estimate based on data still incomplete at time of submitting this paper.

The possible influence of geographical location was also considered and the data obtained are presented in Table 3.

\* Chief, Medical Service, Tripler Army Hospital. Now Medical Consultant, GHQ, Far East Command.

† Senior Resident in Internal Medicine, Tripler Army Hospital.

Received for publication November 12, 1951.

<sup>1</sup> Carrillo, E. G.: Rheumatic Carditis in a Tropical Country, *Am. Heart J.* 23:170 (Feb.) 1942.

<sup>2</sup> Doolittle, S. E. and Tilden, I. L.: Rheumatic Heart Disease in Hawaii, *HAWAII MED. J.* 1:7 (Sept.) 1941.

<sup>3</sup> Berk, M. E. and Hartwell, A. S.: Five Years of Heart Disease in Hawaii, *HAWAII MED. J.* 8:177 (Jan.-Feb.) 1949.

<sup>4</sup> Connor, A. and Yoshina, T.: Rheumatic Fever in Hawaii, *HAWAII MED. J.* 10:181 (Jan.-Feb.) 1951.



TABLE 3.—*Distribution by Residence of Rejectees.*

	NUMBER REJECTED	% OF THOSE REJECTED	% BY ISLANDS OF TOTAL EXAMINED
Oahu .....	64	61.5	69.1
Hawaii .....	16	15.3	14.1
Maui .....	15	14.5	8.9
Kauai .....	6	5.7	6.2
Molokai .....	....	....	0.9
Lanai .....	....	....	0.8
California .....	2	....	....
Philippines .....	1	....	....

### Data From Literature

The incidence of valvular heart disease in similar groups of examinees on the mainland shows interesting comparisons to the Hawaiian rejection rate of 1.91%. Eames, McGill and Clark<sup>5</sup> found 2.84% rejection rate for "Rheumatic and Valvular" causes in the examination figures of all induction stations for the years 1940-1 and 1.65% for the years 1942-3. Rowntree, McGill and Edwards<sup>6</sup> report a rejection rate of 1.49% for rheumatic heart disease and valvular heart disease in 45,585 examinees 18 and 19 years old. Shaffer<sup>7</sup> found 1% incidence of "Rheumatic Valvulitis" in 25,000 Texas examinees age 18-35. It is also interesting to note that in World War I<sup>8</sup> "The estimated incidence of rheumatic heart disease among young adults (21-30) in the U. S. Draft of 1918 was 15.7 per thousand." Paul<sup>9</sup> in his review of epidemiology of rheumatic fever states that 1 to 4% of children in the temperate zone have rheumatic heart disease. Many other similar studies could be quoted.

The low incidence of knowledge of prior rheumatic fever (22.9%) in Hawaiian rejectees also makes an interesting comparison. Levy,<sup>10</sup> in discussing rejectees of the New York area, states "a history of rheumatic fever was found in a little over one-fourth of all cases of rheumatic heart disease." Levy-Stroud and White<sup>11</sup> in discussing re-examination of 4,994 men rejected for cardiovascular defects, find that "only 28.8% of those disqualified for rheumatic valvular disease gave a history of rheumatic fever." Delaney, Miller and Kimbro<sup>12</sup> found that of 100 cases of valvular

heart disease age 18-27 chosen for study "35 patients (35%) on careful questioning admitted some manifestation of rheumatism."

In regard to the distribution of diagnoses of valvular heart disease, the literature was not as consistent either in percentage findings or nomenclature, and for purposes of comparison was of little value. If the reader is interested, Levy, Stroud and White,<sup>11</sup> Delaney, Miller and Kimbro<sup>12</sup> and Salisbury<sup>13</sup> have presented the most applicable studies.

### Comment

The method of physical examination which established our figures should be scrutinized for validity of the end result. Induction examinations are necessarily one-day sessions insofar as the inductee is concerned, and a production line project insofar as the professional staff is concerned. Whenever a murmur or other finding, potentially disqualifying, was discovered, the patient was re-examined by a senior resident in medicine; and if there was still a question of doubt, the case was further reviewed by the Chief of Medical Service or some other qualified individual. Routine posteroanterior chest x-rays were taken on all candidates. When other supporting data were indicated, EKG's, function tests, additional x-ray exposures, etc. were obtained. If decision was still in doubt, inductee was returned at a later date for further re-examination and reconsideration. Conservatism was the rule in making diagnoses and rejections.

The sources of error in this type of examination are at once apparent. Nevertheless, the figures reported are regarded as acceptable, inasmuch as it must be obvious that as many men with heart disease were missed as were erroneously diagnosed valvular heart disease. The crux of the situation is the interpretation of murmurs when other supporting data are not adequately confirmatory. Thus the principle sources of error will lie in the diagnosis of mitral insufficiency alone and aortic stenosis alone, inasmuch as any diastolic murmur is to be regarded as organic in origin.

Although prior knowledge of rheumatic fever in those rejected for valvular heart disease is low in the group herein reported, it is not sufficiently so to be regarded as significant; we believe it can be regarded only as a trend.

Likewise neither the racial nor the geographical data can be regarded as significant. The conclusion to be drawn seems to be that there are no factors in the various island localities which foster

<sup>5</sup> Eanes, R. H., McGill, K. H. and Clark, M. L.: Cardiovascular Defects in Selective Service Registrants, *Am. Heart J.* 32:504 (Oct.) 1946.

<sup>6</sup> Rowntree, L. G., McGill, K. H. and Edwards, T. I.: Causes of Rejection and Incidence of Defects Among 18 and 19 Years Old Selective Service Registrants, *J.A.M.A.* 123:181 (Sept. 25) 1943.

<sup>7</sup> Shaffer, C. F.: The Incidence of Rheumatic Valvulitis in Military Induction Examinations With Special Reference to Cardiac Evaluation, *Texas State J. Med.* 41:300 (Oct.) 1945.

<sup>8</sup> Defects Found in Drafted Men, Gov't Printing Office, Washington, D.C., 1920.

<sup>9</sup> Paul, J. R.: Epidemiology of Rheumatic Fever, *Am. J. Med.* 2:66 (Jan.) 1947.

<sup>10</sup> Levy, R. L.: The Stimulus of War to Cardiology, *Bull. New York Acad. Med.* 122:237 (May) 1946.

<sup>11</sup> Levy, R. L., Stroud, W. D. and White, P. D.: Report of Re-examination of 4,994 Men Disqualified for General Military Service Because of Diagnosis of Cardiovascular Defects, *J.A.M.A.* 123:937 (Dec. 11) 1943.

<sup>12</sup> Delaney, J. H., Miller, S. I., Kimbro, R. W. and Bishop, L. F. Jr.: Valvular Heart Disease Previously Unrecognized in Military Medical Examinations, *J.A.M.A.* 123:884 (Dec. 11) 1943.

<sup>13</sup> Salisbury, A. H.: Asymptomatic Heart Disease, Observations Made During the Early Recruiting Period for Navy and Marine Enlistment, *Am. J. Med.* 5:351 (Sept.) 1948.

a higher rate of rheumatic fever. This would seem to rule out exposure to tourists, which is higher on some islands than others, as a factor. Although racial incidence would seem higher in the Japanese and much lower in the Filipinos than expected, these conclusions must be scrutinized closely with skepticism due to the inherent errors in the study. With these considerations in mind, the data have been presented only for whatever informational value they may have.

### Conclusions

1. Assuming (1) that the lesions designated by common usage as rheumatic heart disease are in fact due to rheumatic fever, and (2) that the group examined is a representative sample or cross section of the population of Hawaii,

the conclusion can be drawn that rheumatic fever is in fact common in the islands and approaches in percentage the incidence found on the mainland.

2. There is no significant difference in prior knowledge of antecedent rheumatic fever among those exhibiting valvular heart disease between Hawaiian youths and those on the mainland.
3. There is no significant difference in distribution of rheumatic heart disease between the islands. This conclusion would seem to eliminate the possible factor of an increased incidence due to contact with tourists.
4. Based on this study alone, no valid conclusions can be drawn concerning the racial incidence of rheumatic heart disease.



# A Dental Survey of United States Army Inductees in Hawaii

ROBERT J. FANNING, MAJOR, D.C., U.S.A.\*  
HONOLULU

THE draft laws passed last year, authorizing the induction of men into the U. S. Army in age brackets of 19-26 inclusive, made it possible to conduct a dental survey on an age group in the Hawaiian Islands on which practically no detailed data have been available.

In dealing with the problem of dental conditions, the status of the first permanent molars should merit special consideration. These teeth are often lost early in life with subsequent deleterious effects upon the development, maintenance, and function of a normal masticatory apparatus. Moreover, from a public health point of view, it has been suggested that age-specific mortality rates of first permanent molars may be used as an index in evaluating the effectiveness of preventive and corrective caries control programs instituted among school populations.<sup>1</sup>

## Procedure

This investigation covers 3,346 U. S. Army inductees of the Hawaiian Islands. According to their records, all were residents of the islands and had not served in the Armed Forces during World War II. Non-residents and veterans were eliminated for the purpose of obtaining as homogeneous a group as possible.

Dental examinations were made with the use of mouth mirror and explorer in good natural light combined with a dental spotlight. Carious lesions recorded were those which could be observed on a careful clinical examination. Exams were performed at the time of the individual's pre-induction physical. No x-rays were taken. Third molars were included in the observations. All missing teeth were assumed to have been lost because of extensive caries. Inductees were examined by one dental officer assigned to Tripler Army Hospital Dental Clinic, Honolulu, T. H., using the same method of examination for all men, which fact adds more uniformity to the collected material.

The following items were recorded on the dental examination form: number of teeth indicated

for extraction because of extensive caries; number of teeth indicated for filling detected by explorer; number of missing teeth; number of teeth which had been filled; and number of teeth with defective fillings.

Dental caries experience was measured by counting: number of teeth with extensive caries which were indicated for extraction (E); number of teeth with untreated caries which were indicated for filling (D); missing teeth due to caries (M); number of filled teeth (F); and teeth with defective fillings (DF). DMF (Decayed, Missing, Filled) index number was used to designate past and present caries experience for teeth.

Tooth mortality was computed according to the method used by Knutson and Klein.<sup>2</sup> Calculations of tooth morbidity were based on the number of teeth showing past experience (filled) plus those found carious at the time of examination and indicated for filling.



MAJOR FANNING

TABLE 1.—General Findings; DMF Permanent Teeth of All Races.

AGE	NUMBER OF PERSONS	TOTAL NUMBER OF PERMANENT TEETH	E	D	M	F	DF	DMF
20	9	256	2	15	32	38	4	91
21	203	5,517	251	203	979	1,715	91	3,239
22	1,265	34,277	938	1,237	6,046	11,704	682	20,607
23	597	16,475	651	711	2,671	4,669	148	8,850
24	618	16,967	414	628	2,860	4,517	110	8,529
25	637	17,588	471	755	2,744	3,933	102	8,005
26	17	485	4	20	63	81	4	172
20-26	3,346	91,565	2,731	3,569	15,395	26,657	1,141	49,493

## Findings and Discussion

Table 1 gives detailed DMF findings for the permanent teeth of males between the ages of 20 and 26 years. Number of missing teeth (M) comprises about one-third of the total DMF figure.

<sup>2</sup> Knutson, J. W. and Klein, H.: Studies on Dental Caries. IV. Tooth Mortality in Elementary School Children, Pub. Health Rep. 53:1012, 1938.

Received for publication April 13, 1951.  
\* Tripler Army Hospital.  
<sup>1</sup> Salzmann, J. A.: Variation in Tooth Position Following the Extraction of First Molars in Relation to Incidence and Distribution of Dental Caries, J. Dent. Res. 19:17, 1940.

TABLE 2.—Comparative DMF Rate for Racial Groups Residing in the Hawaiian Islands.

AGE	HAWAIIAN		PART-HAWAIIAN		JAPANESE		CHINESE		FILIPINO		CAUCASIAN		ALL OTHERS	
	No Sub	DMF Rate	No Sub	DMF Rate	No Sub	DMF Rate	No Sub	DMF Rate	No Sub	DMF Rate	No Sub	DMF Rate	No Sub	DMF Rate
20.....	6	13.16	19	14.73	117	17.55	10	13.9	8	10.5	4	11.5	5	9.0
21.....														
22.....	23	14.04	73	13.63	822	17.55	93	15.37	84	10.33	48	16.23	122	14.60
23.....	5	11.4	20	16.30	345	17.32	40	14.72	106	7.54	19	15.15	62	13.09
24.....	4	12.0	33	14.30	344	17.37	23	15.78	147	5.24	15	14.06	52	13.09
25.....	14	12.71	19	15.52	284	17.11	24	15.16	209	5.34	25	16.44	62	12.56
26.....			2	8.0	5	17.60			8	5.37	2	12.5		
20-26.....	52	13.17	166	14.36	1,917	17.41	190	15.18	562	6.55	126	15.77	333	13.43

The number of filled teeth (F) constitutes over one-half of the total DMF figure. The number of carious teeth (E) which are beyond the possibility of repair, carious teeth which can be filled, and teeth with defective fillings make up about one-sixth of the total DMF figure. The few individual samples for age 20 and 26 rule out any possibility of reaching any significant conclusions.

In a previous study,<sup>3</sup> it was found that Japanese children had a higher DMF rate than other racial groups. One of the aims of this paper was to observe variations in the caries experience of the various racial groups residing in the islands.

TABLE 3.—Comparison of U.S. Army Hawaiian Draftees with Caries-Free Four 1st Permanent Molars According to Racial Groups.

RACE	NUMBER OF DRAFTES	AGE LAST BIRTHDAY								% WITH CARIES- FREE 1ST MOLARS
		20	21	22	23	24	25	26	20-26	
Hawaiian	52		1		1			2	3.8	
Part-Hawaiian	166	5	4	1	2	1		13	7.8	
Japanese	1,917		15	9	7	9		40	2.1	
Chinese	190	1	4	2	1	1		9	4.7	
Filipino	562	2	13	29	58	99	4	205	36.4	
Caucasian	126		1				1	2	1.6	
All Others	333	1	11	11	3	6	9	41	12.3	
Total Number	3,346	1	20	48	44	75	120	4	312	9.5

Data given in Table 2 provide information as to the dental caries experience (DMF) in terms of teeth per inductee of each racial group. The average number of DMF teeth does not increase with chronological age. Filipino inductees examined were numerous enough to show a significant difference in their DMF teeth rate from the other groups. The Japanese had the highest all-round DMF teeth rate. Figures per inductee per racial group were as follows: Filipino (6.55), Hawaiian (13.17), all others (13.43), part-Hawaiian (14.36), Chinese (15.18), Caucasian (15.77), and Japanese (17.41).

A comparison of inductees from the Hawaiian Islands with four caries-free first permanent molars according to racial groups is shown in Table 3. Filipino men have the greatest percentage of caries-free first molars with 36.4, followed by all others with 12.3, part-Hawaiian

with 7.8, Chinese with 4.7, Hawaiian with 3.8, Japanese with 2.1, and Caucasian with 1.6. Of the Filipinos 184 were born in the Philippine Islands.

Among the Filipino men, those born in the Philippine Islands and reared in the Hawaiian Islands had less dental caries than those of second and third generations born and reared in the Territory of Hawaii.

The large number of missing teeth in addition to the number of teeth which require extraction because of extensive caries may be attributed to the economic status of the families from which the majority of the inductees come. Klein and Palmer,<sup>4</sup> after studying the dental status of school children of forty communities in New Jersey, concluded that the economic status of the community in which the children lived did not affect the incidence of dental caries, but that it influenced the amount of dental service given to the individual. The more prosperous the community was, the greater the amount of dental care received. This means that more teeth are saved by fillings and less are neglected to such an extent as to require extraction. At the same time, such factors as better understanding of the importance of dental health and the distribution of dentists throughout the islands may influence the DMF rate in Hawaii.

#### Summary

Of the age groups examined, the Filipino showed the greatest difference (lowest) in the number of DMF teeth per subject, while the Japanese had the highest incidence of dental caries.

The relatively few individuals with four caries-free first permanent molars reaffirms strongly the belief that the preservation of these molars can be accomplished only by early systemic care, since the highest susceptibility to caries occurs at a relatively early age.

The large percentage of teeth missing and the number of teeth which require extraction because of extensive caries may be due to the financial status of the families from which the men come, as well as other factors.

<sup>3</sup> Fanning, R. J.: Incidence of Dental Caries Among School Children in the Hawaiian Islands, *HAWAII MED. J.* 11:22 (Sept.-Oct.) 1951.

<sup>4</sup> Klein, H. and Palmer, C. E.: Community Economic Status in the Dental Problems of School Children, *Pub. Health Rep.* 55:187, 1940.



# Dental Caries in 205 Students of Japanese Ancestry at the University of Hawaii

CAREY D. MILLER, M.S.,\* AGNES C. BICKERTON, M.S.,†  
and GERALD L. PARKE, D.D.S.‡

HONOLULU

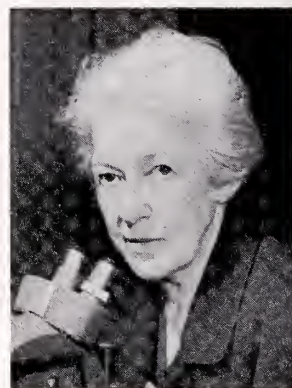
ALTHOUGH some studies of the caries of children of elementary school age in Hawaii have been published,<sup>1</sup> few or no data are available for college students.

In 1936, under the direction of the senior author, two students made a diet and dental study of 90 high school and university students with the assistance of Dr. Dorothy Dudley, a practicing dentist in Honolulu with experience in public health dentistry. It seems worthwhile recording the dental findings for this hitherto unpublished study as they serve as a fitting preliminary for the larger study here reported.

All of the 90 subjects were of Japanese ancestry, born in Japan or Hawaii, and had lived in Hawaii most of their lives. The students (44 males and 46 females) were examined in Dr. Dudley's office and the examinations charted on dental record cards issued by the Bureau of Public Relations of the American Dental Association. No roentgenograms were made. Two males, ages 15 and 16, but no females, had perfect teeth. There were too few subjects to justify tabulations for each year, but the data have been grouped in Table 1 to illustrate any trends in DMF (Decayed, Missing, or Filled) rate with age. Using the data for individuals, the regression of DMF rate on age gave a coefficient of 0.671 ( $t = 1.60$ ) for males and a coefficient of 0.320 ( $t = 1.43$ ) for females. Although neither of these coefficients differs significantly from zero, the fact that they are both positive suggests that even in this small group of 90 students there is an increase in DMF rate with age similar to that found by Hollander

and Dunning<sup>2</sup> in their study of more than 12,000 subjects. For this group of 90 students there were 71 (19.72 per cent) missing first molars and only 47 or 13.06 per cent of the first molars were sound.

The DMF rates per subject shown in Table 1 are definitely higher than those for students 17 and 18 years of age in Hagerstown, Md., San Francisco, and New York City reported in the classical studies of Klein and Palmer<sup>3</sup> where the DMF rates were around 7 and 8.



MISS MILLER

TABLE 1.—Preliminary Data (1936) on Mean DMF Rates\* for 90 Subjects of Japanese Ancestry in Hawaii.

AGE GROUPS	MALES		FEMALES	
	Number	DMF	Number	DMF
14-17 .....	6	10.66	18	12.88
18-20 .....	19	12.05	11	13.90
21-22 .....	15	14.00	8	15.88
23-26 .....	4	12.50	9	15.11
All Age Groups....	44	12.57	46	14.09

\* Decayed, missing, or filled teeth per person.

Since Brekhush<sup>4</sup> has shown a deterioration in the teeth of freshman students at the University of Minnesota over a 20 year period (examinations at 10 year intervals), we might well expect a similar trend in Hawaii.

Personal observations of the senior author at the University of Hawaii led her to believe that Oriental students, especially those of Japanese ancestry, had, over a period of 20 years, grown taller but had shown deterioration in dental conditions.

<sup>2</sup> Hollander, F. and Dunning, J. M.: A Study by Age and Sex of the Incidence of Dental Caries in Over 12,000 Persons, *J. D. Res.* 18:43 (Feb.) 1939.

<sup>3</sup> Klein, H. and Palmer, C. E.: On the Epidemiology of Dental Caries. University of Pennsylvania Bicentennial Conference, Dental Caries, Philadelphia, University of Pennsylvania Press, 1941.

<sup>4</sup> Brekhush, P. J.: The Deterioration of Human Teeth, *J.A.D.A.* 42:424 (April) 1951.

From the Foods and Nutrition Department, Hawaii Agricultural Experiment Station, Honolulu.

Published with the approval of the Associate Director of the Hawaii Agricultural Experiment Station as technical paper number 224.

Received for publication Oct. 12, 1951.

\* Professor Foods and Nutrition, University of Hawaii.

† Head, Dental Hygiene Department, University of Hawaii.

‡ Commander (DC) U. S. Navy. Present address, Bureau of Medicine and Surgery, Department of the Navy, Washington, D. C.

<sup>1</sup> Millberry, G. S.: A Study of the Dental Problem in Hawaii, Dept. Pub. Instr. and Strong Foundation, Honolulu, 1930. Potgieter, M.: The Adequacy of Diets of 38 Honolulu Families on Relief and Suggestions for Obtaining a More Adequate Diet on a Limited Budget, Univ. of Hawaii Agr. Expt. Sta. Bul., 94, 1944. Larsen, N. P.: Fluorine in Control of Children's Tooth Decay, *Postgraduate Medicine*, 2:358 (Nov.) 1947.

All these facts led us to believe that more information on present dental conditions in Hawaii is needed for those interested in a program to improve dental health and to present a true picture of the situation to parents and to the students themselves.

This is the first report on a project designed to study stature, dietary history, and dental caries of University students in the Hawaiian Islands.

TABLE 2.—*Condition of Teeth of 205 Selected University of Hawaii Students.*

	MEN	WOMEN
Number of students.....	104	101
Average age .....	19.31	19.58
Students with perfect teeth.....	0	0
Mean DMF rates per person		
1. Without x-rays and omitting 3rd molars.....	17.41 ± 0.51*	17.50 ± 0.43
2. With x-rays and omitting 3rd molars .....	17.90 ± 0.52	18.26 ± 0.43
3. With x-rays and including 3rd molars if filled or decayed .....	19.13 ± 0.54	19.36 ± 0.46
Active caries		
Proportion of students with caries.....	95.19%	99.01%
Average carious teeth per student for group..	7.00	8.09
Average carious teeth per student with caries	7.35	8.17
Missing permanent teeth (exclusive of 3rd molars)		
Proportion of students with.....	72.12%	64.36%
Average number teeth extracted for group....	2.19	1.91
Average per student with extractions.....	3.04	2.97
Proportion of students with one or more impacted third molars.....	61.54%	55.44%
Proportion of students with one or more devitalized teeth.....	19.23%	19.80%
Proportion of students with one or more abscesses .....	19.27%	7.92%

\* Standard error of the mean.

### Subjects and Procedure

Students of Japanese ancestry were selected first since they constitute the largest group of Oriental ancestry at the University. Only those born in Hawaii and who had lived here continuously were studied. Students in Health and Physical Education classes were asked to volunteer to cooperate in the study. From the volunteers it was possible to obtain a fairly good representation from all the Islands in the Hawaiian group on the basis of population figures.

Oral clinical examinations were made by the dental hygienist (A.C.B.) while the nutritionist (C.D.M.) acted as recorder and made graphic records indicating size and extent of fillings, carious areas, and missing teeth. The teeth were examined in good daylight using an S. S. White No. 17 explorer and a dental mirror ( $\frac{7}{8}$  inch  $\times$  4 magnification). Compressed air and special lighting were not available for the examinations. If the explorer sank into a pit or spot without apparent caries but touched softened tissue it was recorded as active caries. A recheck was made on each subject before he or she left the chair.

Full periapical and bite-wing roentgenograms were made in a professional x-ray laboratory. The dentist of the group (G.L.P.) then checked the roentgenograms with the clinical examination records and recorded cari-

ous areas, abscesses, root canal fillings, impactions, etc. as found by roentgenograms. The records and roentgenograms were given a final checking by the dentist and the nutritionist before tabulations of data were made.

Using the technic recommended by Snyder<sup>5</sup> the color changes in bromcresol-green dextrose agar when incubated with saliva were recorded for all women students. The students were given paraffin, a sterile widemouthed bottle, and printed instructions to chew the one gram paraffin tablet in the morning upon awakening, before drinking or eating and to collect the saliva in the bottle and bring it to the laboratory. With few exceptions two saliva samples were obtained, ranging from a week to a month apart. The colors of the tubes were recorded at intervals of 24, 48, 72, and 96 hours after inoculation with saliva. On the basis of color changes, the results were tabulated as negative, questionable, and active caries. Ninety out of 101 women collected the saliva samples as requested. No saliva samples were collected from the men.

### Results and Discussion

The results of the present study are summarized in Figures 1 and 2 and Table 2. Comparisons with data on students of college age elsewhere are given in Tables 3, 4, and 5.

Pertinent data relating to the dental conditions of the 205 students are summarized in Table 2. The DMF rates per subject on the basis of clinical examinations only and exclusive of third molars were  $17.41 \pm 0.51$  for men and  $17.50 \pm 0.43$  for women. The rates rose to  $19.13 \pm 0.54$  for men, and  $19.36 \pm 0.46$  for women when the DMF rates included additional affected teeth shown by x-rays plus third molars if filled or decayed.

Sixty-four men (61.54 per cent) had 119 seriously impacted third molars and 56 women (55.44 per cent) had 113. The number per student varied from one to four.

The proportion of men and women having devitalized teeth was high, more than 19 per cent in each group. Abscesses were not uncommon; 18.27 per cent of the men and 7.92 per cent of the women had one or more abscessed teeth. Two men had three abscessed teeth each, three had two each, and the others had one each. Only one of the men was aware that he had an abscessed tooth and that was because he had a fistula.

The DMF rates of more than 17 per person (not counting those found by x-rays and omitting decayed and filled third molars) for these 205 young people appear high when compared with 13 and 14 for Oregon State College<sup>6</sup> and Uni-

<sup>5</sup> Snyder, M. L.: A Simple Colorimetric Method for the Diagnosis of Caries Activity, J.A.D.A. 28:44 (Jan.) 1941.

<sup>6</sup> Hadjimarkos, D. M. and Storvick, C. A.: The Incidence of Dental Caries Among Freshman Students at Oregon State College, J. D. Res. 27:299 (June) 1948.



versity of Minnesota freshmen<sup>4</sup> (Table 3).

Since no other data on high school or college age students (except those of our preliminary study in 1936, Table 1) were available from recent studies in Hawaii, compilations were made from record cards prepared by the dental hygienist at a Honolulu high school and from the records for students who voluntarily went to the University of Hawaii dental hygiene clinic for prophylaxis and checking. From inspection of Table 3 it may be seen that the group in our study have a higher DMF rate than the high school students. This might be expected in view of Hollander and Dunning's<sup>2</sup> study previously mentioned. Our group also has a higher DMF rate than students of Japanese ancestry attending the University dental hygiene clinic. There is, however, no way of knowing whether the latter are representative of the student body or if they may represent only those who have greater interest in the condition of their teeth and therefore go to the clinic for examination. Comparison of the data for all Hawaii subjects given in Table 3 with those for the preliminary study in Table 1 indicates a trend toward increased dental caries in a period of 10 to 12 years.

TABLE 3.—Mean DMF Rates for Permanent Teeth of Students at a Honolulu High School, University of Hawaii, and Four Other Groups.

	TOTAL NUMBER OF STUDENTS		MEAN DMF RATE	
	Men	Women	Men	Women
A Honolulu High School (av. age 15) (Japanese) (1947-1948).....	288	257	12.72	14.85
University of Hawaii				
This Study (1948-1949).....	104	101	17.41	17.50
Japanese Students Attending Dental Hygiene Clinic (1947-1949).....	171	230	14.38	15.78
All Students Attending Dental Hygiene Clinic (1947-1949).....	285	353	13.60	14.81
Oregon State College (1948).....	235	347	13.60	14.35
University of Minnesota (1949).....	4,412		13.7	
Aviation Cadets U.S.A. (1943)				
48 States .....	7,170		15.17	
14 States .....	1,803		18.98	
Enlisted Airmen, R.N.A.F. (1944) .....	1,000		21.3	

A comparison may also be made with the caries experience of the aviation cadets examined by Senn<sup>7</sup> (Table 3). In 1943 he studied the DMF rates of 7,170 aviation cadets between the ages of 18 and 27 years from 48 states. He states that these men represented a good cross section of urban and rural areas and that they all came from average or better than average environments where they should have had better than average opportunities for dental care. From his data, presented for each of the states, we have calculated the mean

DMF rate to be 15.17 per subject. By states they ranged from 9 to 21 DMF per cadet. We also calculated that 1,803 cadets, from 14 states that had mean DMF rates of 18 to 21, had an average rate of 18.98 per cadet. These figures are based on examinations without x-rays and may be compared with similar figures for our males without x-rays. These 1,803 cadets represented a group having a higher DMF rate (18.98) than our males (17.41).

TABLE 4.—Comparison of Missing and Sound First Permanent Molars of University of Hawaii and Oregon State College Students.

	SEX	NO. OF STUDENTS	TOTAL NO. OF FIRST MOLARS	MISSING			SOUND		
				No.	Percent	Rate per Student	No.	Percent	Rate per Student
Hawaii	Male	104	416	85	20.4	0.82	24	5.8	0.23
Oregon	Male	224	896	62	6.9	0.28	89	9.9	0.40
Hawaii	Female	101	404	79	19.6	0.78	19	4.7	0.19
Oregon	Female	316	1,264	88	7.0	0.28	100	7.9	0.32

Another group of young men (age range 17 to 30, average 23.5 years) which showed a higher DMF rate than our students were the airmen of the Royal Norwegian Air Force which Sognnaes<sup>8</sup> examined in Canada. Among other findings his report shows the high DMF rate of 21.3 per man (Table 3).

The number of missing permanent teeth is usually considered a good index of dental care as well as past nutritional history. For the Hawaii group, 71.12 per cent of the men and 64.36 per cent of the women had missing permanent teeth (exclusive of third molars). The rate for subjects having extractions is nearly the same for men and women (3.04 per man and 2.97 per woman). Table 4 gives a comparison of the missing and sound first permanent molars in the Hawaii and Oregon students. As indicated by chi-square tests, both men and women in Hawaii show a significantly greater per cent of missing teeth and a smaller per cent of sound first molars than do the Oregon students<sup>9</sup>.

Few extracted teeth had been replaced. Per 100 subjects, the men had 219 missing teeth with 10.96 per cent of them replaced, and the women had 191 missing teeth with 23.31 per cent replaced.

The condition of the incisor teeth of our 205 subjects may be noted in Figures 1 and 2, and a

<sup>7</sup> Senn, W. W.: Incidence of Dental Caries Among Aviation Cadets, Mil. Surg. 93:461 (Dec.) 1943.

<sup>8</sup> Sognnaes, R. F.: Studies on Aviation Dentistry. Dental Conditions in a Group of 1,000 Airmen. National Research Council, Ottawa, May 1944, Part II.

<sup>9</sup> Hadjimarkos, D. M. and Storvick, C. A.: Mortality and Morbidity of First Permanent Molars in Freshman College Students, Oral Surg., Oral Med. and Oral Path. 3:250 (Feb.) 1950.

comparison with the University of Minnesota students is made in Table 5. The low percentage of perfect upper central incisors compared to the Minnesota students is very striking, the men having approximately 14 per cent and the women only about 6 per cent perfect teeth compared with approximately 57 and 59 per cent for the Minnesota students. Comparisons of the other incisor teeth also demonstrate that the Hawaii students have a low proportion free from dental caries.

A discussion of all the probable causes of the dental conditions of these 205 subjects is not within the scope of this paper but it may be mentioned that comparisons of the DMF rates for students from the different islands showed no marked difference. Nor did the birthplace of the parents appear to be a factor. Fifty-eight men whose parents were born in Japan had an average DMF rate of 17.90, 18 men whose parents were born in Hawaii had a DMF rate of 17.89, and 28

who had one parent born in Hawaii and one in Japan had a DMF rate of 17.93. The figures for the women showed no greater difference when classified on the basis of birthplace of parents.

An analysis of the data on the color changes in bromocresol-green dextrose agar when incubated with saliva showed poor correlation with the number of carious teeth when new cavities and leaky fillings were counted as active caries. Twenty-one students rated negative, 24 questionable, and 45 active. The mean values per student for active caries in each group were 6.10, 8.50, and 9.29 respectively. All students except one that rated negative had from 1 to 12 actively carious teeth. The DMF rates for the groups were as follows: negative 17.0, questionable 19.90, and active 20.36. In view of these results on the female subjects, saliva samples were not requested from the men.

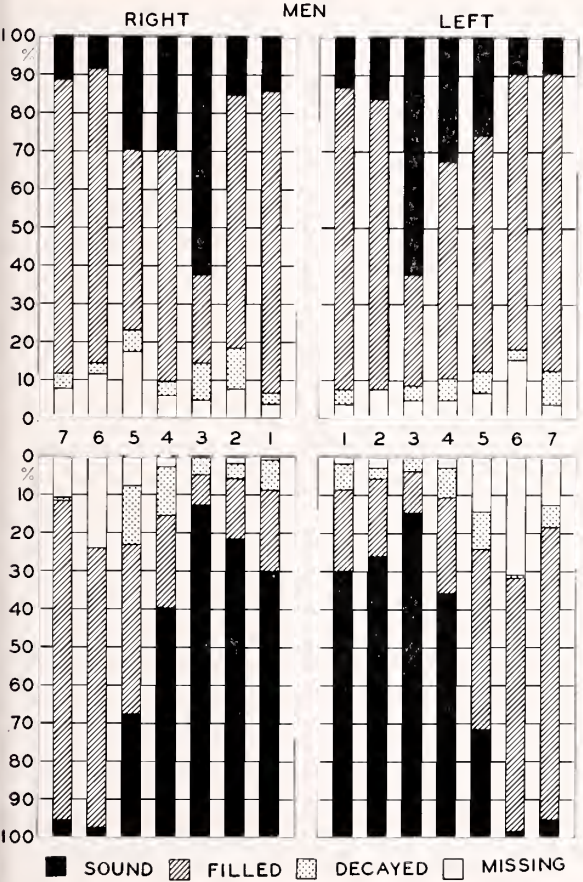


FIG. 1.—Percentages of sound, filled, decayed, and missing teeth in 104 male subjects. Upper teeth are shown in the upper graph, and lower teeth in the lower graph. The numbers indicate the different teeth, e.g. 1, the central incisors and 7, the 2nd molars.

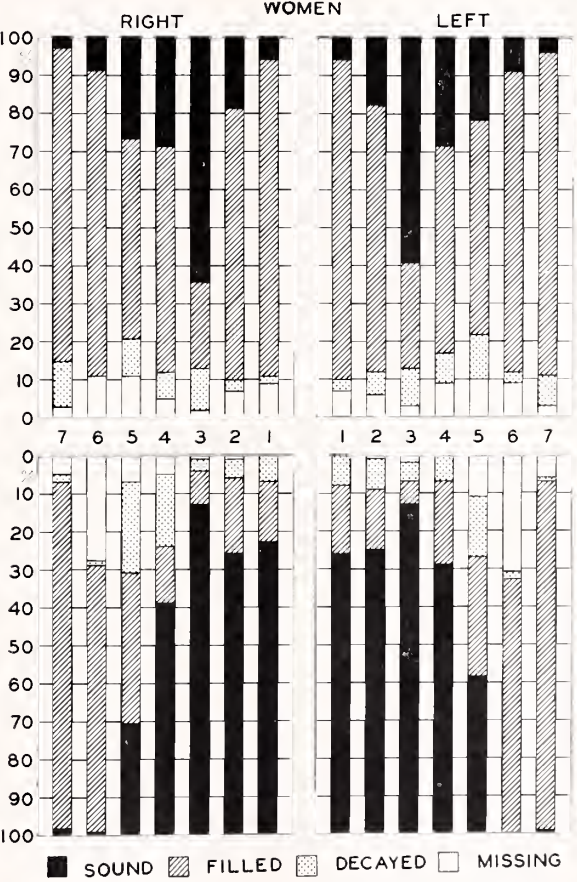


FIG. 2.—Percentages of sound, filled, decayed, and missing teeth in 101 female subjects. Upper teeth are shown in the upper graph and lower teeth in the lower graph. The numbers indicate the different teeth, e.g. 1, the central incisors and 7, the 2nd molars.



The high morbidity and mortality rates for all permanent teeth, the low proportion of perfect teeth, especially for upper central incisors and first and second molars, and the number of devitalized and abscessed teeth for 205 young men and women of Japanese ancestry indicate a serious dental condition.

TABLE 5.—Percentage of Perfect Incisor Teeth In a Selected Group of University of Hawaii Students Compared with Freshman Students, University of Minnesota.\*

	RIGHT LATERAL	RIGHT CENTRAL	LEFT CENTRAL	LEFT LATERAL
MEN				
Upper				
University of Hawaii.....	15.38	14.42	13.46	16.35
University of Minnesota....	57.84	56.65	57.95	56.93
Lower				
University of Hawaii.....	78.85	70.19	70.19	74.04
University of Minnesota....	93.54	93.47	94.03	94.17
WOMEN				
Upper				
University of Hawaii.....	18.81	5.94	5.94	17.82
University of Minnesota....	60.18	58.07	59.33	59.29
Lower				
University of Hawaii.....	74.26	77.23	74.26	75.25
University of Minnesota....	96.15	96.02	95.63	96.21

\* Data on University of Minnesota students examined in 1949 have been furnished through the courtesy of Dr. W. H. Crawford, Dean of the School of Dentistry.

### Summary

One hundred and four men and 101 women of Japanese ancestry born in the Hawaiian Islands and residents here throughout their lives, who were enrolled in the University of Hawaii, co-operated in a study of their dental conditions. Their average age was 19 years.

The DMF rates, when additional cavities found by the use of x-rays and carious and filled third molars were included, were  $19.13 \pm 0.54$  for men and  $19.36 \pm 0.46$  for women. These rates are much greater than those reported for freshmen students at the University of Minnesota and Oregon State College but are less than those reported in the literature for two groups of men in military service in the United States and Canada.

Data are presented for the proportion of all permanent teeth decayed, missing, and filled and for devitalized and abscessed teeth.

Geographic location (residence on one of four islands for most of their lives), and birthplace of parents appeared to have no influence on the DMF rates.

Tests of caries activity using bromocresol-green dextrose agar showed such poor correlation with the number of carious teeth for the women that the tests were not repeated for the men.

### Acknowledgments

The authors are indebted to Adelia Bauer for carrying out the color tests with bromocresol-green dextrose agar and to Mildred Higa for assistance in tabulating the data and preparing the graphs.

The senior author wishes to thank Dr. Dorothy Dudley for examining the teeth of the 90 students mentioned in the preliminary study.

Thanks are also due staff members of the Department of Health and Physical Education and the students who cooperated in the study.

# A Routine Admission X-ray Program in a General Hospital

ELIZABETH H. MIDDLETON, R.N., ADELE P. SCHLOSSER,  
AND MARION C. BURNS  
LIHUE, KAUAI, AND HONOLULU

**D**URING the past five years, mass x-ray surveys have been accepted and promoted as the most productive method of case finding for previously undetected tuberculosis in the community. In the past two or three years, however, the percentage of cases found through this means has decreased markedly, especially in areas such as the Territory of Hawaii where surveys have been conducted at regular intervals; and this change is most noticeable for *new* cases of tuberculosis.

There has been a gradual change in the age group in which tuberculosis is most prevalent. At the present time, while tuberculosis is still a major communicable disease problem in the age group from 19 to 35, the greatest number of *new cases* is being found among older persons, especially men of 45 and over. Although the general response to mass surveys has been most encouraging, and this type of case finding accounts for the majority of new cases of tuberculosis, many public health workers have expressed the opinion and studies show that the very individuals for whom a chest x-ray is most important—older men—are failing to participate in this screening process. For example, it was found that in the 1947 mass survey in Honolulu, more than half of most age groups in the population were x-rayed. Persons over 45 years of age, however, constituted only 23 percent of the total of 92,207 x-rayed, while 45 percent of the active cases were found in this age group.

One of the most practical and effective methods suggested for reaching this older age group has been through x-raying all of the admissions to general hospitals. Credit should be given to the American Hospital Association which has for years urged its member hospitals to institute an admission chest x-ray program. Studies have demonstrated many times that more cases of tuberculosis may be expected in this so-called "sick segment" than in the general population. With the institution of a general admission chest x-ray program,

too, a hospital is more alert to the patient-to-patient contact and also can protect its personnel from otherwise undetected tuberculosis. Finally admission x-rays are becoming increasingly important as a means of discovering other types of chest pathology, a matter of grave concern to both the patient and the physician.



MISS MIDDLETON

In a recent article in "Health News," Dr. Siegal of the New York State Health Department made the following statement: "... The routine chest x-ray examination of adult patients admitted to general hospitals is an economical and at the same time a most valuable method for finding new cases of tuberculosis in the community. It reaches individuals, especially in the older age groups, who ordinarily are not reached through the clinics or in mass x-ray surveys. The program does not require as extensive community planning or organization as does a mass x-ray survey. Nevertheless, it yields twice the number of new cases of tuberculosis."<sup>1</sup>

## Wilcox Hospital X-Ray Survey

In January, 1950, the G. N. Wilcox Memorial Hospital of Lihue, Kauai, T. H., instituted a routine chest admission program. The initial step of the Superintendent was to secure the acceptance by the Board of Trustees and the interest and cooperation of the medical staff and the hospital personnel.

The G. N. Wilcox Memorial Hospital is a 93 bed institution with an average of admissions of 250 patients a month, and it was decided to use the 14 x 17 equipment already available in its x-ray department. To make the program acceptable to the patient, the admission chest x-ray was presented as a procedure which would be as routine as the usual laboratory workup. The cost of this admission x-ray was set at \$3.00, to be shared equally by the hospital and the patient. It was

<sup>1</sup> From the G. N. Wilcox Memorial Hospital, Lihue, Kauai, and the Tuberculosis Association of Hawaii.

Received for publication November 6, 1951.

<sup>1</sup> Siegal, William, M.D., "Chest X-rays of Hospital Admissions," New York State Health News, Vol. 27, No. 12, December, 1950.



gratifying to see the awakened patient interest in the program as evidenced by the inquiries that were made concerning its purpose, and no objection was encountered when the charge appeared on the patient's bill.

It was recognized that the system would have to be flexible in order to meet new problems as they arose. At the end of the first six months, it was found that the existing x-ray department and clerical staff were unable to handle this increased volume of work. As a result it was necessary to engage a full-time x-ray technician and an additional clerical worker. In the first year of the program, all patients except newborns were considered eligible for the routine admission x-ray.

Responsibility for the admission chest x-ray is shared by the admitting clerk, the x-ray technician, and the medical records librarian. The routine chest x-ray is generally taken shortly after admission and is combined with the admitting procedure in the following manner. On the admission of a patient, the admitting clerk checks the master card file to ascertain whether this is a new patient or a readmission. In either case one of the quadruplicate admission forms is sent to the x-ray technician with a notation indicating no previous x-ray or the date of a previous one. Under this program only one routine chest x-ray is taken yearly. Depending upon the findings of this routine x-ray or the symptoms revealed in a later admission, subsequent chest x-ray will be taken only on order of the attending physician.

In recording the data of the routine chest x-ray, the medical records librarian checks in the x-ray Record Book the date on which the routine chest x-ray was taken. Using a code letter, she enters this information on the patient's card in the master file and also on a special 3 x 5 file card which has been set up for a detailed study of the program at the end of five years. This special card shows only pertinent information, such as the hospital file number, the patient's name, sex, age, x-ray findings, diagnosis at the time of admission, and disposition; i.e., referral to a private physician or admission to a tuberculosis hospital. From these data, the medical records librarian prepares a monthly statistical summary.

All chest films are read by the roentgenologist; and in cases of possible tuberculosis or cancer, a consultation is available by the medical superintendent of the local tuberculosis hospital. If tuberculosis is suspected, laboratory procedures are instituted to verify the diagnosis. When findings are positive, the patient is transferred as soon as a bed is available to the local tuberculosis hospital.

In January, 1951, on the recommendation of the roentgenologist, children under ten years of age were excluded from the study as no pertinent findings relative to pulmonary tuberculosis in this group had been found in 1950.

### Results

For the first nineteen months of operation of this program, the results have left no doubt of the value of routine chest x-ray for all adult admissions. Since January, 1950, 3,010 chest films have been taken, representing approximately 92 percent of the groups eligible for admission x-rays, excluding newborn, children under ten years of age, and readmissions with previous routine chest x-ray in the current year. Of these 3,010 chest films, 2,496 were read as negative and 513 or 17 percent showed some abnormality. The median age of a selected group of the latter was 53.8 years, which indicates that an older group is being reached than is usual in mass surveys.

The following table gives an analysis of the pathology:

TABLE 1.—*Disease Revealed by Routine Admission X-ray Classified by Previous Diagnosis, January 1, 1950-July 31, 1951.*

DIAGNOSIS	TOTAL	PREVIOUSLY DIAGNOSED	NOT PREVIOUSLY DIAGNOSED
All diagnoses .....	513	188	325
Possible Pulm. TB.....	26	2	24
Pulm. TB, I, activity undetermined.....	18	2	16
Pulm. TB, probably active.....	7	1	6
Pulm. TB, I, probably inactive.....	10	2	8
Pulm. TB, II, activity undet.....	3		3
Pulm. TB, II, probably inactive.....	1		1
Pulm. TB, III, activity undet.....	7	4	3
Pulm. TB, III, active.....	3	1	2
Pulm. TB, (old) healed.....	35	5	30
Tuberculoma .....	1		1
Lung disease <sup>2</sup> .....	148	83	65
Heart and lung disease.....	12	3	9
Heart .....	227	81	146
Cancer .....	6	2	4
Other .....	9	2	7

As this table shows, 63.3 percent of the pathology found had not been previously diagnosed. Of the 513 diagnoses of some disease, 72 or 14 percent of the total were possible tuberculosis or definite tuberculosis with undetermined activity, besides 3 cases that were diagnosed as pulmonary tuberculosis, III, active. The results of admission x-rays of all adults become even more startling in view of the fact that of the 72 cases of possible tuberculosis and the 3 cases of advanced tuberculosis, 63, or 84 percent, had not been previously diagnosed. Further diagnostic workup revealed sputum positive for acid fast bacilli, and 15 patients were transferred to the local tuberculosis hospital. Ten of the patients with diagnosis

<sup>2</sup> Includes upper respiratory infections, fibrosis, calcification, pneumonitis, etc.

of pulmonary tuberculosis, I, and one case of pulmonary tuberculosis, II, were proven to be in an inactive stage of the disease. In addition, 35 patients were found to have old healed tuberculous lesions; and only 5 of this group had previously been diagnosed. This information was recognized as important because of the fact that all known cases of tuberculosis should be followed in view of the tendency of this disease to recur and relapse. As Dr. E. M. Medlar, Chief of the Laboratory Service at the Veterans Administration Hospital at Sunmont, New York, has pointed out: "If tuberculosis is to be controlled, the unrecognized spreaders of the bacilli . . . must be sought out and properly cared for. No more fertile field can be cultivated in this program than the obtaining of chest x-rays on admission of all patients to all general hospitals. Special effort should be directed toward males beyond thirty-five years of age. In such a program it is to be hoped that cases deemed clinically *inactive* will *not* be forgotten. Inactive cases can and do spread bacilli. They can and do become clinically active."<sup>3</sup>

A general hospital admission chest x-ray program can make an invaluable contribution to a tuberculosis control plan for a community, because, at the hospital level, it will reach a segment of the population which generally does not participate fully in a mass survey program. This study has brought out the fact that the median age of patients who received an admission chest x-ray at the G. N. Wilcox Memorial Hospital is higher than that previously found in other community surveys.<sup>4</sup> For this reason alone, the opportunity that is afforded a general hospital in finding pulmonary tuberculosis in the age group over 45 years of age should not be ignored.

There have been many problems to work out in developing the program to its present status of an accepted hospital procedure. Any hospital contemplating such a routine admission x-ray program should realize that the full value of such a project rests upon the recording of the chest x-ray findings and their transmission to a permanent form of card file or other recording medium which will make readily available pertinent and accurate data

for statistical reports, future study or research projects. The time and effort involved in the clerical work alone cannot be overlooked.

Budget-conscious administrators should be fully aware of the cost of such a program. The net cost to this hospital for the past year was at least \$4,000. At the G. N. Wilcox Memorial Hospital, certain steps have been found necessary in order to reduce expense. For instance, paper films are now being used advantageously. A recheck chest x-ray is taken on a regular 14 x 17 film and charged at the regular rate. Any savings in the use of less expensive materials help to offset the increased cost of administration.

Every effort should be made to realize the goal of the program; that is, to take an admission x-ray on every patient eligible for the study. If the average number of routine chest x-rays falls below a certain percentage of the total admissions (and at this time 75 percent is considered a minimum standard) the program becomes less effective and will not warrant the expense involved. Even with this case finding program functioning as a routine procedure of admission, it will still be necessary for the administrator to stimulate and maintain the interest of the medical staff by the presentation of a monthly statistical report and by simplification of departmental procedures to expedite the recommended diagnostic workup or the transfer to a tuberculosis hospital.

### Conclusion

In the nineteen months since its inception at the G. N. Wilcox Memorial Hospital, the admission chest x-ray program has certainly proved its value, not only in the yield of positive diagnoses of pulmonary tuberculosis, but in revealing, also, the equally significant findings of unrecognized thoracic conditions, such as heart disease and lung disease of a non-tuberculous nature, especially in the older age group. The data related to pulmonary tuberculosis have shown that the routine admission chest program definitely fulfilled its main purpose, that of finding new and unsuspected cases of pulmonary tuberculosis and thereby protecting the general public as well as other patients and hospital personnel from an infectious disease.

<sup>3</sup> Medlar, E. M., M.D., editorial in New York State Health News, Vol. 27, No. 12, December, 1950.

<sup>4</sup> In the 1947 Honolulu city-wide survey, the median age of the total group x-rayed (92,207) was 38.1 years.





**Doctor,  
be your own  
judge...  
try this  
simple test**

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

**Take a PHILIP MORRIS and any other cigarette**

- 1.** Light up either one first. Take a puff—get a good mouthful of smoke —and s-l-o-w-l-y let the smoke come *directly* through your nose.
- 2.** Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between

PHILIP MORRIS and any other leading brand.

**PHILIP MORRIS**

Philip Morris & Co. Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

# Hawaii

# MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D. Editor  
MRS. EDITH C. BENNETT Managing Editor  
WILLIAM JOHN HOLMES, M.D. News Editor  
HASTINGS H. WALKER, M.D. Advisory Board  
HOMER IZUMI, M.D. Advisory Board  
PETE OKUMOTO, M.D. Associate Editor, Hawaii  
EDWARD S. KUSHI, M.D. Associate Editor, Maui  
C. H. ISHII, M.D. Associate Editor, Kauai

## [ EDITORIALS ]

### NEW CYTOLOGIC TECHNIC FOR GASTRIC CANCER

The Cytology Laboratory of the Hawaii Cancer Society was established in July, 1949, under the direction of a committee of physicians trained in cytologic diagnosis. The technical work has been under the supervision of Mrs. Esther Chinn. This laboratory has been of considerable aid to physicians in the diagnosis of cervical and bronchopulmonary cancer, as reported at the 1951 meeting of the Territorial Medical Association.<sup>1</sup>

In cancer of the cervix, a properly made smear, obtained by scraping the squamous-columnar junction of the cervix with a wooden spatula, contains a sampling of cells from this entire cancer-bearing area, and cells with malignant characteristics can be readily recognized by the trained person. If such a smear contains normal cells only, the possibility of cancer, or even of epithelial anaplasia, is extremely remote in that particular patient. Actually a smear of this sort may be more sensitive than a random biopsy or even multiple biopsies in detecting evidence of early cancer.

The presence of "suspicious" cells, on the other hand, does not necessarily mean carcinoma, since such cells may be shed from areas of epithelial anaplasia which have not yet progressed to actual carcinoma. In such cases one must obtain biopsy material from the cervix. Multiple punch biopsies are usually done first, and if these are negative and the "suspicious" cells persist, one may do a coning or ring biopsy, whereby the entire squamous-columnar junction of the cervix is removed for pathologic study. *In no case should definitive treatment be instituted on the basis of the smear findings alone.* It is vitally important

to have tissue studies in order to determine whether or not carcinoma is actually present, and if so whether or not it is invasive. Actually the type of treatment will often depend upon the results of the tissue study.

Although extremely useful in cervical and bronchogenic carcinoma, the cytologic method has been disappointing in gastric cancer. This is so for two reasons. First, the cells in fasting gastric contents, and even in saline wash specimens, are apt to show deterioration because of the acid present; and second, the presence of mucin makes it difficult to obtain good preparations.

A method of overcoming these obstacles, developed by Rosenthal and Traut,<sup>2</sup> consists of injecting into the stomach, after removal of the fasting gastric contents, 500 cc. of a buffered solution containing papain. This material is recovered after fifteen minutes, centrifuged, smeared, and stained in the usual way. The buffered solution neutralizes the acid, and the papain, which is a proteolytic enzyme, digests mucin, making it possible to obtain good preparations.

The Cytology Laboratory of the Hawaii Cancer Society now has additional technical help in the person of Miss Jean Kawamura, and is prepared to carry out the papain technic described above in selected cases. Physicians are therefore urged to contact the Cancer Society if they wish to try out this method of diagnosis in cases of suspected gastric carcinoma.

#### Cytology Committee

I. L. TILDEN, M.D.  
F. C. SPENCER, M.D.  
W. B. QUISENBERRY, M.D.

<sup>1</sup> Spencer, F. C., Tilden, I. L., and Quisenberry, W. B.: Report of Hawaii Cancer Society Cytology Laboratory, HAWAII MED. J. 10:437-438 (July-August) 1951.

<sup>2</sup> Rosenthal, M., and Traut, H. F.: Mucolytic Action of Papain for Cell Concentration in the Diagnosis of Gastric Carcinoma, Cancer 4:147-149 (Jan.) 1951.



## SIXTY-SECOND ANNUAL MEETING HAWAII TERRITORIAL MEDICAL ASSOCIATION

Honolulu, Hawaii

May 1 through 4, 1952

### *The Pathology of Intercellular Substance*

WILLIAM BOYD, M.D., Professor of Pathology and Bacteriology, University of Toronto Faculty of Medicine

### *An Evaluation of Present Methods of*

#### *Treatment of Pulmonary Tuberculosis*

HOWARD BOSWORTH, M.D., Clinical Professor of Medicine, University of Southern California School of Medicine

Also the following papers:

### *Treatment of Alcoholism, with*

#### *Special Reference to Antabuse Therapy*

J. ROBERT JACOBSON, M.D.

### *Fracture of the Carpal Navicular*

COL. CARL M. RYLANDER, M.C., A.U.S.

### *Glaucoma as Related to General Disease*

O. D. PINKERTON, M.D.

### *The Cutaneous Manifestations of Systemic Disease*

HAROLD M. JOHNSON, M.D.

### *The Place of Radical Surgery in the Treatment of Cancer of the Uterus*

ROBERT HUNTER, M.D.

### *Care of the Cleft Lip and Cleft Palate Child*

WAYNE W. WONG, M.D.

### *Pulmonary Embolism and Infarction*

HENRY C. GOTSHALK, M.D.

### *Abdomino-Pelvic Pain*

RODNEY T. WEST, M.D.

### *Diagnostic Problems in*

#### *Infectious Mononucleosis*

CAPT. J. L. VAN AVERY, M.C., A.U.S.

### *The Use of Dermal and Cutis Grafts in Inguinal Hernioplasty*

ROBERT C. JOHNSTON, M.D.

## A.M.A. DUES

A.M.A. dues must be paid by June 1 of each year—not, as previously reported, by December 1 of the following year. They become delinquent June 2, and loss of membership occurs 30 days after notification of delinquency has been mailed. We presume this applies to dues for 1952 and succeeding years, not to 1950 or 1951.

Reinstatement of lapsed membership will not require repayment of accumulated back dues, as originally stated; only the dues for the year of delinquency and the year of reinstatement must be paid.

Fellowship dues have been abolished, but Fellowship status is still available on application and still required for participation in A.M.A. meetings.

A.M.A. membership is limited to active members of county medical societies, entitled to vote and hold office therein, except for commissioned

officers in the armed forces who become Service Fellows. The latter pay no dues and receive no *Journal*.

A.M.A. dues may be forgiven, by the Board of Trustees, for:

1. Members partly or wholly excused from dues by their local society because of (a) *financial hardship*, (b) being in *training* within five years after graduation, or (c) *having retired* from practice; or

2. Members *over 70 years of age* (forgiveness starts January 1 following the seventieth birthday); or

3. Members *called to active duty* with the armed forces (forgiveness starts January 1 or July 1 after active duty starts).

*No others need apply.* "Honorary" and "life" members who cannot qualify in one of the above categories must pay or be dropped. "Associate" members of county societies cannot join the A.M.A. at all. It should be noted that members excused from paying dues are also excused from receiving the *Journal*, except by personal subscription at the usual price of \$15 a year.

## CATASTROPHIC HEALTH INSURANCE: II

The Home Insurance Company of Hawaii now offers insurance against catastrophic medical expenses, and we are happy to make this space available for a brief description of their policy, just as we made it available to the Liberty Mutual Insurance Company in our last issue.

Their policy resembles Liberty Mutual's in offering \$5,000 maximum coverage per person and in having a \$500 deductible provision. It differs from Liberty Mutual's in having also a \$200 deductible clause, if this is preferred, and in covering *all* expenses above this deductible amount instead of only three-fourths of them. Premium for a family of 4 is \$9.00 per month for the \$200 deductible policy and \$5.63 per month for the \$500 deductible one, if both parents are under 45 years of age.

It is obvious that plans like these take up where the ordinary voluntary medical insurance plans have to leave off, namely, at the point where the illness begins to be catastrophically expensive. They are complementary to them, not competitive with them.

It seems apparent that insurance against medical and hospital expenses is gradually evolving into a pattern similar to that of automobile collision insurance, which is just as it should be. Patients and physicians must try to withstand the temptation to abuse these insurance plans. If they do, the

plans may yet succeed in silencing the socializers' clamor for not only drifting but actually paddling in the direction of the so-called Trend toward the socialization of the practice of medicine. In the long run, we will very likely get just about what we deserve. Fifty million voters will decide what is to be done, and "Fifty million [Americans] can't be wrong!"

#### **KAPIOLANI HOSPITAL REVERSES A "TREND"**

When an agency of government lets go of a job it has been doing, and a private agency carries the job on, that is news. The reverse process is so commonplace nowadays that it is rather taken for granted; indeed, it seems probable that it would qualify as a Trend. It is always encouraging to see one of these Trends get smacked down, even in a small way, so sacrosanct have they become in recent years. It helps to dispel the growing impression that they are inviolable Jugernauts which it is useless to resist.

We have just learned that this has happened, in a modest way, at the Kapiolani Maternity and Gynecological Hospital, where the Territorial Department of Health has been conducting an Out-patient Clinic for obstetrical cases. On September 1, 1951, the hospital took over the responsibility for staffing and maintenance of this institution. Dr. H. E. Bowles is the first acting consultant obstetrician, and the clinic will be staffed by the four residents at the hospital.

We should like to extend our congratulations to Mr. Kent Longnecker, administrator of the hospital until very recently, for his part in not only opposing but actually reversing a Trend.

#### **TEXAS INSTITUTION FOR SPASTICS**

The treatment of the various ills of mentally normal children, who respond with relative facility to conventional therapy, is not difficult to undertake; but when it comes to attempting to do something for the more unattractive, slowly responsive patients, regardless of their age, an extra quantity of the "Milk of Human Kindness" must be possessed by the therapist who attempts such a difficult task.

A National Society for the care of both crippled children and adults has interested itself particularly in the large group of children known as "spastics." It deserves great credit for its special work with this group of children, so frequently individually repulsive, and for interesting many medical people in this great problem which has been neglected so long.

An interesting brochure descriptive of this type of work in a Waco, Texas institution has recently been received, which describes in detail, in lay language, the care of some of these "truly hopeless" unfortunates. The writer, who has been in the crippled children's work for many years, was most favorably impressed, and was happy to hear from the country's best authorities on the subject that this newly organized institution for these children is looked on with favor.

Aloha to Dr. Herbert E. Hipps and his staff who are doing such a worthwhile job with that large group of children, particularly the hopeless ones, suffering from what is generally called "cerebral paralysis."

J. WARREN WHITE, M.D.

#### **COMMUNITY CALENDAR OF EVENTS**

**When you plan a meeting, no matter how far ahead, please clear it with the Volunteer Placement Bureau at 5-7436 or 51-0115 to make sure it doesn't conflict with the date of other meetings and to enable them to register it on their Community Calendar of Events.**

**There is no charge for this valuable community service. It should help attendance at your meetings and keep**

**your organization from interfering with, or being interfered with by, other groups who might be planning a meeting on the same night.**

**You can obtain a copy of the Community Calendar from the Volunteer Placement Bureau on request. Their address is now 420 South Hotel Street, and Mrs. A. L. Faye is the Chairman in charge of the Calendar.**



# MEDICAL NEWS

**Prantal**, a new parasympatholytic agent, **suppresses gastric motility** and secretion of hydrochloric acid more effectively than Banthine, according to Margolin, et al. of the Schering Laboratories (*Proc. Soc. Exp. Biol. & Med.* 78:576 [Nov.] 1951). More welcome news is the near absence of mydriasis and dry mouth so common with adequate doses of Banthine. The drug is still under investigation.

A rash of (not from) **new mercurial diuretics** is described by Hardley, et al. (*Proc. Soc. Exp. Biol. & Med.* 78:433 [Nov.] 1951). Three new compounds (the world shortage of paper prohibits repeating their chemical names here) were found to produce three to four times the diuretic effect of, and to have a wider margin of safety than, Mercuhydrin (which is ranked with Thiomerin as the safest, most potent mercurial now available).

**Hetrazan**, the wonder drug which has done so much for filariasis in the past three years, is now hailed by Laughlin, et al. (*Lancet* 261:1197 [Dec. 29] 1951) as less toxic and more effective than hexylresorcinol (mouth burns in children) and oil of chenopodium in the treatment of **ascariasis**. It is given in a syrup, 13-20 mg./Kg B<sup>o</sup>, for four days, and results in 80 per cent cures. The job waiting for this drug is outlined by the fascinating estimate that in China 355,000,000 people are infested with ascarids enough to equal the weight of 442,000 men, and they produce 18,000 tons of eggs yearly (the ascarids do, that is).

In an excellent review of the problem of **retinal vein thrombosis**, Duff, Falls and Linman conclude that **anti-coagulants** are unquestionably of value. Short-course heparin treatment was as effective as, and safer than, long-term dicumarol treatment. An unexpected dividend was a reduced incidence of glaucoma in the treated cases. (*Arch. Ophthalm.* 46:601 [Dec.] 1951.)

Mims describes a buffered solution of **methylcellulose** for **ophthalmic** use (*Arch. Ophthalm.* 46:664 [Dec.] 1951). It is used: (1) to replace deficient tear secretion often found in persons past age 50; (2) as a lubricant for enucleation prostheses; (3) as a protective and analgesic solution for corneal irritations and infections.

"**Quatane**" (Smith, Kline, & French) **relieved itching** 80 per cent of 258 times it was used in a wide gamut of dermatoses, according to Lynch and Ockuly (*Arch. Dermat. & Syphilol.* 65:35 [Jan.] 1952). More notably, it aggravated the dermatitis in only one patient, which is an unusual record for any antipruritic drug.

**Mytolon chloride** (Winthrop-Stearns) is a new member of the growing family of **muscle relaxants** so useful in surgery. Tubocurarine has the advantage of de-

pressing certain dangerous reflexes, Decamethonium has evanescent action, and Mytolon is free of any effect on the cardiovascular system, and respiratory depression recedes promptly. (Arrowood, J. G., *Anesthesiol.* 12: 753 [Nov.] 1951.)

Best available treatment for infections due to **Pseudomonas aeruginosa** (*Bacillus pyocyaneus*) is **Polymyxin B**, says Jawetz (*Arch. Int. Med.* 89:90 [Jan.] 1952). Purification has almost eliminated the renal toxicity of polymyxin, and bacterial resistance developed in only one of 35 patients.

Four different ways of **blocking the sympathetics** produced symptomatic relief in a case of **acute porphyria** treated by Wehrmache (*Arch. Int. Med.* 89:111 [Jan.] 1952). Cramping pain in the abdomen, calves and buttocks was relieved by injections of tetraethylammonium (Etamon) chloride, Priscoline, tubocurarine, and by splanchnic sympathetic block.

**Induction of labor** is easier and faster if the uterus is "sensitized" with **intravenous Progynon** in propylene glycol (30,000 rat units q. four to twelve hours [I.V.]), according to Kurzrak and Streim (*Am. J. Surg.* 83:117 [Jan.] 1952). The method is of particular value in missed abortions where the softness of a uterus carrying a dead pregnancy increases the risks of curettage.

A **hot, humid environment** is a serious threat to patients with **congestive failure**, as shown by Berenson and Burch (*Am. J. Med. Sci.* 223:45 [Jan.] 1952). Ten of twelve subjects in mild congestive failure promptly went into serious left heart failure when placed in a room with a temperature of 40° C. and 85 per cent humidity. Perhaps the ice is as important as the O<sub>2</sub> in an oxygen tent. An air-conditioned ward for cardiac patients has been suggested by these authors.

**Moniliasis** after antibiotic therapy is such a problem that the Council on Pharmacy decided a warning to this effect should be added to the labels of Aureomycin, Terramycin and chloramphenicol (April, 1951). A possible solution is offered by McVay and Sprunt (*Proc. Soc. Exp. Biol. & Med.* 78:759 [Dec.] 1951). They added a preservative used for many years in foods and drugs, **Paraben** (parahydroxybenzoic acid) which is effective against yeasts and molds, to the capsules of Aureomycin. This did not eliminate pre-existing moniliasis in any patient, but *new* infections were down to 13 per cent, compared with 63 per cent for Aureomycin without Paraben.

Irrefutable logic: "It is of interest also that there were no females in the group since all were males." (Linton, Robert, Mass. Gen. Hosp., in *Angiology* 2:486 [Dec.] 1951.)

C. A. DOMZALSKI, JR., M.D.

# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*

MRS. FLORENCE GRAY, *Assistant Librarian*

Phone 65370

8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.

Monday through Friday

Closed Saturdays at noon and Sundays

Closed all day and evening on National holidays  
and at noon on Territorial holidays

---

## Recent Acquisitions

### Cancer

Ayre, J. E. *Cancer cytology of the uterus*. c1951. (gift of publisher)

### Cardiology

Rinzler, S. H. *Cardiac pain*. c1951. (gift of publisher)

### Circulatory System

Page, I. H. *Hypertension*. Rev. 1st ed. c1943. (gift of publisher)

Youmans, W. B. *Hemodynamics in failure of the circulation*. c1951. (gift of publisher)

Zweifach, B. W., ed. *Factors regulating blood pressure*. Transactions of the 5th conference, Feb. 15-16, 1951. c1951. (gift of Josiah Macy, Jr. Foundation)

### Dietetics

Mitchell, H. H. *Nutrition and climatic stress*. c1951. (gift of publisher)

### Digestive System

Hoffbauer, F. W., ed. *Liver injury*. Transactions of the 9th conference, April 27-28, 1950. c1951. (gift of Josiah Macy, Jr. Foundation)

### Drugs

Derbes, V. J. *Untoward reactions of cortisone and ACTH*. c1951. (gift of publisher)

### Genito-urinary System

Bradley, S. E., ed. *Renal function*. Transactions of the 2nd conference, October 19-20, 1950. c1951. (gift of Josiah Macy, Jr. Foundation)

### Geriatrics

Shock, N. W., ed. *Conference on problems of aging*. Transactions of the 13th conference, Feb. 5-6, 1951. c1951. (gift of Josiah Macy, Jr. Foundation)

### Neurology and Psychiatry

Bosselman, B. C. *Neurosis and psychosis*. c1950. (gift of publisher)

Friedman, A. P. *Modern headache therapy*. c1951. (gift of publisher)

Nachmansohn, David, ed. *Nerve impulse*. Transactions of the 2nd conference, March 1-2, 1951. c1951. (gift of Josiah Macy, Jr. Foundation)

Wolff, H. A. *Pain*. c1948. (from the Board of Medical Examiners)

### Nursing

Morrissey, A. B. *Rehabilitation nursing*. c1951. (gift of publisher)

### Public Health

Maxcy, K. F. *Rosenau's preventive medicine and hygiene*. 7th ed. c1951. (gift of publisher)

### Roentgenology

Frimann-Dahl, J. *Roentgen examinations in acute abdominal diseases*. c1951. (gift of publisher)

### Surgery

Brown, J. B. *Plastic surgery of the nose*. c1951. (gift of publisher)

Hampton, O. P. *Wounds of the extremities in military surgery*. c1951. (gift of publisher)

Roen, P. R. *Atlas of genito-urinary surgery*. c1951. (gift of publisher)

### Therapeutics

Formulary Committee. *Formulary and therapeutic guide*. c1951. (gift of publisher)

Jones, J. M., ed. *Physician's desk reference for pharmaceutical specialties and biologicals*. 1952. c1951. (gift of publisher)

### Miscellaneous

Graves, Charles. *The story of St. Thomas's (1106-1947)*. c1947. (gift of Mrs. Illa Storme)

Kelly, E. C. *Encyclopedia of medical sources*. c1948.

1 1 1

The Library offers physicians on the outside Islands the same services as are available to Honolulu doctors. These include research and reference work upon request, either by letter or telephone. Books or journals available in the Library are mailed out to any member of the Territorial Medical Association. The Library pays postage from Honolulu, and the borrower assumes return postage charges. *Bound volumes* are now available for a loan period of *three* days. In order to expedite their return to the Library, the Library Board has stipulated that a bound volume should be sent out by air freight, and returned after three days by air. We wish to invite every doctor in the Islands to make use of the resources of the Medical Library.



## BOOK REVIEWS

---

### **Aphorisms of C. H. Mayo and William J. Mayo.**

Collected by Frederick A. Willius, M.D., 117 pp., Price \$2.75, Charles C. Thomas, 1952.

This is a book of phrases and extracts of deep thoughts from various lectures and papers of the famous Mayo brothers. It is light reading and relaxing. It reflects much of the individualistic thoughts and the wisdom of these brothers. The deep humanitarianism and worldly understanding of these great minds can readily be seen by reading between the lines. There are two excerpts—one from a letter and another from a public address—which give the reader a clear cut impression of the parental influence of the father of these men that first inspired them and finally led them to their accomplishments, illustrating the power of team work and great foresight.

I. A. KAWASAKI, M.D.

### **Cancer Cytology of the Uterus.**

By J. Ernest Ayre, M.D., 407 pp. with illustrations, Price \$14.50, Grune & Stratton, Inc., 1951.

This book is primarily an atlas of cytology as applied to the diagnosis of carcinoma of the cervix. Approximately 350 magnificent illustrations, more than one-fifth in color, depict the variety of cell types found in smears obtained from the cervix by the author's "surface biopsy" (scraping) technic in the normal state, inflammatory conditions, anaplastic states of the cervical epithelium, carcinoma in situ and invasive carcinoma. Many excellent photomicrographs illustrate anaplasia of the cervical epithelium, carcinoma in situ and invasive cancer, often in conjunction with the cytologic smears.

The photomicrographs illustrating carcinoma in situ are entirely convincing, unlike many that I have seen published which have merely shown lesser degrees of epithelial anaplasia.

Despite the author's enthusiasm for cervical cytology, he mentions that treatment—with one possible exception—still rests upon histologic study of biopsy material. The possible exception is the patient with a conclusive cytologic picture, negative biopsies and a clinically benign appearing cervix. Dr. Ayre believes that total hysterectomy may be considered in such a patient, particularly if she is past the child bearing age, in the absence of histologic confirmation of the malignancy. This statement may be objected to by many.

The discussion on methods of obtaining biopsy material from the cervix is excellent and will be approved by most pathologists.

As an atlas to demonstrate the morphology of normal and abnormal cells in smears obtained from the cervix, this book is by far the best that has appeared.

I. L. TILDEN, M.D.

### **Rosenau's Preventive Medicine and Hygiene.**

By Kenneth F. Maxcy, M.D., Dr.P.H., 1462 pp., Price \$14.00, Seventh Edition, Appleton - Century - Crofts, Inc., 1951.

The advent of a new edition of Rosenau's *Preventive Medicine and Hygiene* is an eagerly awaited event in the field of public health. The first edition of this classic was published in 1913 and the sixth in 1935. It has taken until 1951 to produce the seventh and present edition, which was started by Kenneth Maxcy in 1942 but did not materialize until 1951, during which time the whole field of preventive medicine underwent radical changes. The present book could not have been written in 1942.

Practically the whole book has been re-written and gives a completely modern orientation in the field of public health with all of its specialties. The lists of references have been completely revised and abound with 1950 and 1951 articles to document recent work. Newly discovered diseases such as histoplasmosis and toxoplasmosis are reviewed. Use of the new antibiotics and chemotherapeutic agents are, for the most part, well covered. The excellent article on drug addiction, which is certainly part of public health, is omitted from this edition. The article by Lester Breslow on Senescence, Chronic Disease and Disability in Adults is recommended reading for all physicians. The 1,462 pages packed with information embracing all phases of public health makes this an almost indispensable book for public health workers, and can be highly recommended. I have just received my copy. Other Bureaus in the Department of Health have their copies on order.

JAMES R. ENRIGHT, M.D.

### **Modern Dietetics.**

By Doris Johnson, B.S., M.S., 529 pp., Price \$4.95, G. P. Putnam's Sons, 1951.

This text for the student nurse covers the usual subjects of normal nutrition, diet therapy, and the selection, care, preparation and cookery of foods. One-fifth of the book is devoted to all the tables and charts needed by the student nurse. A few island foods are included, as many as could be expected in a book written primarily for use on the mainland.

The field is well covered, but as expected where so much information is included in one book, facts are not elaborated upon, and few details are given.

The Basic Menu Plan is emphasized throughout the book, especially in the section on Diet Therapy. It, too, is meant for mainland use and the patterns would need to be modified to fit the various racial dietary plans used in the islands.

On the whole the book seems well planned and with supplementary reading would make a valuable text.

VIRGINIA COOKSEY

### **Roentgen Examinations in Acute Abdominal Diseases.**

By J. Frimann-Dahl, M.D., Ph.D., 321 pp. with 357 illustrations, Price \$10.50, Charles C. Thomas, 1951.

This excellent book by one of Europe's foremost radiologists is intended for use primarily by the roentgenologist, the internist and surgeon as an aid in the establishment of the diagnosis of acute abdominal conditions and especially in those complex problems where surgery may be indicated.

There are chapters on Technique of Procedure, Preparation of the Patient, Apparatus, the Normal Roentgen Anatomy, and General Pathologic Findings of the abdomen with secondary lesions of the chest; also a section on Special Pathologic Findings, such as obstruction, herniation, malformation, vascular changes and infectious and inflammatory changes. It includes a chapter on the use of the Miller-Abbott tube by Jack Friedman, M.D., of this country.

All pathologic cases presented in this work have been verified either at operation or necropsy, or by the clinical course. The death rate of acute abdominal conditions has fallen considerably since the introduction of the roentgen examination and can fall still lower with judicious use of the material covered in this book.

PETER J. WASHKO, M.D.

### **The Glaucomas.**

By H. Saul Sugar, M.D., 469 pp. with illustrations, Price \$12.00, C. V. Mosby Company, 1951.

This book is the outgrowth of a series of lectures and papers on the subject of increased intraocular pressure presented to graduate students in ophthalmology. The text is well written, adequately illustrated, and printed on a good grade of paper. It includes an extensive bibliography but most of the references are dated before 1949. Because several excellent review articles on the subject of glaucoma have been published recently, the impression gained after reading the text is that there are no startling advances and very little of an original nature. It is a text book written primarily for those beginning the study of ophthalmology. However, because glaucoma is such a fascinating subject, every ophthalmologist should read this book to review the fundamental basis of ocular hypertension and also use it as an addition to his library.

ROBERT T. WONG, M.D.

### **Plastic Surgery of the Nose.**

By James Barrett Brown, M.D. and Frank McDowell, M.D., 427 pp., Price \$15.00, C. V. Mosby Company, 1951.

Brown & McDowell's book would be well worth while having for those who are interested in this type of surgery. The book is rather complete in its description of all aspects of nasal deformities with many photographs of their "before and after" cases. The correction of cleft lip and associated nasal deformity and the more destructive lesion caused by cancer or war are also included. The book is without references so that one gets the impression it is entirely original, but this is done for simplicity and brevity.

WAYNE W. WONG, M.D.

### **Wounds of the Extremities in Military Surgery.**

By Oscar P. Hampton, Jr., M.D., F.A.C.S., 434 pp., Price \$10.00, C. V. Mosby Company, 1951.

This book should be especially valuable to the new medical officer, whatever his age or experience in civil life. Injured soldiers are treated by many echelons before they are finally received in a general hospital where definitive care can be outlined and carried out. This book points out the reasons for the basic principles which are now in use in the military service as far as traumatic wounds are concerned.

The concepts of proper wound management in World War I are mentioned and the reasons why some of the World War I ideas were changed are reviewed very well.

The basic principles of initial wound surgery are fully reviewed. This is followed by a description of reparative and reconstructive surgery and a full explanation of why these stages are necessary in military surgery. The book finally takes up special wounds, compound fractures and shows how the basic principles should be applied to these special conditions. The book is well written and profusely illustrated, and should be a valuable source for teaching.

DEAN M. WALKER, M.D.  
Colonel, M.C., U.S.A.

### **Modern Headache Therapy.**

By Arnold P. Friedman, M.D., 164 pp., Price \$4.00, C. V. Mosby Company, 1951.

It is interesting that so little has been written on the origin and treatment of headache, particularly when it is such a common symptom.

This monograph offers a sensible approach to the proper management of this complaint. Much of the book is devoted to a method of making a correct diagnosis as to the type and origin of the headache. The therapeutic approach offered is logical and well presented.

This book is written principally for the general practitioner. It is well indexed and contains 164 pages.

HENRY C. GOTSHALK, M.D.

### **Neurosis and Psychosis.**

By Beulah Chamberlain Besselman, M.D., 182 pp. with 88 cs. histories, Price \$4.50, Charles C. Thomas, 1950.

This short book presents the various psychiatric disturbances in a brief, clear and interesting manner. Both the major and minor illnesses are discussed, although there is no attempt at a comprehensive study. Didactic in form, the book presents in each instance the general psychodynamics involved in the development of the illness and a well-selected illustrative case history.

The author explains the psychoanalytic approach to these problems in a way that is not too difficult for the general physician-reader to follow. Though her classification of the disorders may be debatable (she lists postpartum psychoses separately from schizophrenia, for instance), this seems far less important than the creation of a more complete understanding of psychiatric symptoms. In the latter the book is of considerable help.

KENNETH H. RUSCH, M.D.





## HMSA—Its Place in the Community

J. R. VELTMAN, *Manager*

A generation ago the practice of medicine was substantially an individual problem between the family physician and his patient. The need for stress of security was not so great, the cost of living not so high, and the cost of medical, surgical, or hospital care not so heavy. The public attitude during this period was to accept illnesses in stride, do what could be done about them, and pay for medical services as the doctor required.

This complacent attitude passed away with the generation it served. A more enlightened public became aware of the need to raise standards of medical care, thereby inspiring the development of highly technical, scientific and medical skills. With each advancement in the medical field came increased costs for the specialized services available. New diagnostic procedures, the development of the miracle drugs, advanced methods of treatment, appliances for orthopedic conditions, all with the primary goal of speeding the recovery of the sick and preventing widespread epidemics, have altered the old passive acceptance of illnesses and cost of medical service. With this altered attitude the public and medical profession became aware that means must be found to obtain necessary care within the ability of the patient to pay. And so it was that cooperative medical care plans developed, at first slowly, then with increasing momentum, as their value became apparent in the endless battle to maintain sound minds and strong bodies.

A cooperative medical service plan for Hawaii had its inception in 1936 when local social workers became interested in equalizing the cost of medical care through community cooperation. This group carried the idea to the doctors, business leaders, and teachers, gaining such a response of interest that the Hawaii Medical Service Associa-

tion was organized and its benefits became effective in June 1938, with 670 members. The medical profession endorsed it, and expressed its support through the adoption of a special fee schedule for services rendered to HMSA members. As a further gesture of good will and support participating physicians authorized certain withholdings to guarantee the solvency of the plan.

Today, fifteen years after its modest beginning, the far-sighted views of the originators and supporters of HMSA are being realized. In the face of a movement in Congress for national compulsory health legislation, Hawaii has its answer in HMSA, a voluntary prepayment plan providing the best possible medical, surgical, and hospital care to the greatest number of people—the working man and his dependents. Doctors find HMSA its bulwark in the fight to maintain medical care as a free enterprise.

January 1952 finds HMSA with 53,000 members embracing citizens in all walks of life, from various phases of industrial activities, and all communities in Hawaii. Its home office is in Honolulu at 1154 Bishop Street, with branches in Hilo, Hawaii; Lihue, Kauai, and Wailuku, Maui. The plan has grown to an extent that it now offers the citizens of the community a choice of three basic plans: Plan I, medical-surgical-hospital; Plan II, surgical-hospital; Plan III, hospital coverage. It is our belief that our participating physicians can be our greatest salesmen to promulgate public interest in HMSA as a necessary community service to keep medical care free from government interference. In view of this we feel it is our responsibility to acquaint you with the actual mechanics of HMSA in this series of articles.

(Next Issue—"Functions of the Committees")

# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## MINUTES OF COUNCIL MEETING

Thursday, January 24, 1952, at 6:00 p.m.

### The Pacific Club

*Present:* Dr. Harry L. Arnold, Jr., presiding; Drs. McArthur (Maui), Wade (Kauai), Tilden, Chung-Hoon, Ito, Gotshalk, R. K. C. Lee; Guests: Drs. Kawasaki, Hartwell, Holmes and Izumi.

*Minutes:* The minutes of the meeting of July 19, 1951, were approved as published.

*Report of the Treasurer:* Dr. Chung-Hoon reported that the financial statement for the ten-months period just ended, plus the figures as estimated to the end of the current fiscal year, indicates a gain of over \$1,000.00, the greater portion of which is reflected in income from the Annual Meeting of May, 1951. The financial status of the JOURNAL was discussed at length. Allocation of the Association's salary expense to the JOURNAL, was likewise discussed. Heretofore all such expense has been borne by the HTMA.

**ACTION:** Dr. Lee moved that the Treasurer break down the costs of the JOURNAL for later presentation to the Council. This was seconded by Dr. Tilden, and unanimously approved.

*Journal Business:* 1. Approval of Dr. Holmes' appointment as News Editor.

**ACTION:** On motion made and seconded, the appointment was unanimously approved.

2. Mark-ups on sales of reprints: Since it is the customary procedure of several of the mainland journals to charge mark-ups of from 5% to 15% (and in one case, 25%), for reprints, Dr. Arnold suggested that this be done by the HAWAII MEDICAL JOURNAL, at least in filling orders for commercial firms.

**ACTION:** On motion of Dr. McArthur, duly seconded, it was voted to charge 15% on commercial orders of reprints of original articles appearing in the JOURNAL. Authors are to be supplied at cost.

3. Tennessee State Medical Association's Letter re *Medicine of the Year* outlines a project which their Association plans to promote this year as a partial solution of their Journal's financial problem. This book, a thumb-nail review of the highlights of medical progress during the preceding year, has been selling as a cloth bound edition, for \$5.00. The publisher agrees to issue a paper bound volume the size of the JOURNAL, with the name of the HTMA imprinted across the front of it, at \$2.00 per copy, to be sent out as a supplement to the JOURNAL. After deducting all costs, the net revenue to the JOURNAL would be about 90c.

After considerable discussion Dr. Gotshalk suggested that the matter be referred to the component Societies. It was Dr. Wade's opinion that a card should be sent to each member after these meetings, on which he should indicate his acceptance or rejection of the book, sign and return.

**ACTION:** Motion was made, seconded and carried, that postcards be sent out at the time of the county

society meetings asking for an expression of the membership's pleasure regarding the purchase of this book.

*Delegate's Report of the AMA Clinical Session:* Dr. Hartwell spoke briefly on the highlights of the interim meeting in Los Angeles in December. The full text of his report appears in the January-February JOURNAL. He was approached many times (after the distribution of orchid leis to some of the officers and delegates), with the request for an interim AMA meeting in Honolulu. This request was of necessity rejected because of lack of hotel accommodations for such a large group here. He suggested that the Association members make a concerted effort to initiate and support a program for adequate hotel facilities in Honolulu for such large groups. He expressed the opinion that the expense accounts of the Delegate and Alternate while attending mainland conventions, should be increased somewhat—at least, those of the Alternate. However, since the budget has not yet been set up for the next fiscal year, the discussion was discontinued.

*Report of the Public Service Committee* was made by the chairman, Dr. Kawasaki, who outlined the Emergency Call Service as organized by his committee and operated by the Nursing Service Bureau. This was a difficult project, started on a three months' trial basis, and still in operation.

In an effort to secure a more equitable adjustment of malpractice insurance rates the Public Service Committee met with the executives of the Home Insurance Company last fall. Following this, Dr. Kawasaki wrote and presented a letter to the Board of Governors of the HCMS, relative to the current upswing of malpractice suits, and possible preventive measures. He suggested that since these suits affect all physicians, a committee be formed to investigate the new insurance rates. He has not been advised of the result of this suggestion.

On Monday, January 28, this committee, the Health Education Committee, and members of the press will meet in joint session to adjust matters of policy regarding news releases. It was agreed at an earlier meeting that the immediate past president of the HCMS should censor all news of a medical nature before release.

A dozen plaques designed by the AMA for improvement of doctor-patient relations, have been ordered for several of the doctors, by Dr. Kawasaki.

*Report of the Scientific Works Committee:* In the absence of Dr. Berk, chairman of this committee, Dr. Arnold reviewed the varied and interesting program arranged for the annual session in May. Both the Tuberculosis Association and the Cancer Society are still endeavoring to find speakers in their specialties who can also talk on general medicine, to come to Hawaii in time to address the Annual Meeting.

*Request of EENT Society for Appointment of Ophthalmological Advisory Board to Bureau of Sight Conservation:*



In introducing this request, Dr. Arnold stated that the Advisory Committee to the Bureau of Crippled Children already has a special sub-committee, composed of six members, to investigate crippling eye conditions in the Territory.

**ACTION:** Dr. Gotshalk moved that this matter be referred back to the EENT Society with the report that the Council does not feel it should take such action; that they should explore the matter thoroughly themselves, and when they are well enough informed, present it to the Governor for action. Motion was seconded and carried.

**Status of Non-Members of the AMA:** Dr. Arnold told the Councillors that seventeen physicians\* have been dropped from the AMA for non-payment of their 1950 dues (or during the first AMA dues paying year). He said that Dr. Lull believed the AMA had nothing to say about the manner of the election of AMA delegates. Some five States have made it obligatory to belong to the AMA in retaining membership in the state association. In the event a member who has been dropped for non-payment of dues, ever wishes to rejoin the AMA he must pay up his delinquent dues. No action was deemed necessary.

**Employee's Salary Increase:** In commenting on the requested salary increase for Miss Florence Isoda, Dr. McArthur reminded the Council that at one time standard procedures for employees' pay increases and other personnel policies, were discussed; no specific plan was evolved at that time, however, but it was felt this is a matter that calls for standard procedures in the future.

**ACTION:** On motion made, seconded and unanimously carried, Miss Isoda's salary was increased \$25.00 per month.

**AMA Education Foundation:** Dr. Arnold stated that this project is not getting the support it deserves; that so far, only one physician in Hawaii has given anything to it. Through this organization subscriptions may be made to the individual school of the donor's choice, and they will be forwarded, without deduction, directly to such schools. This agency is intended mainly to focus public attention on the help that private individuals are giving to the medical schools, and actual figures of the profession's solidarity will thus be available in the event of attempted subsidization by the federal government. It was felt that inasmuch as the national Association regards this a necessary plan, and a great deal of money has gone into it, the members of this Association should support it. No action was taken.

**Recent Appointments to Special Committees:** Dr. Arnold announced recent appointments he has made to the following special committees, mostly for the current calendar year:

\* One physician has since paid. Ed.

Advisory Committee on Chronic Illness  
Advisory Committee to the Bureau of Maternal & Child Health  
Advisory Committee to the Bureau of Crippled Children  
Advisory Council to the Bureau of Mental Hygiene  
Advisory Committee, Hawaii Chapter American Physical Therapy Association  
Committee on Rehabilitation, Oahu Health Council  
Committee, Representatives American Medical Education Foundation  
Board of Management, Mabel Smyth Building

**Payment for Dinners:** The subject of funds to cover the costs of dinners for councillors and guests, was introduced.

**ACTION:** On motion made, seconded and unanimously approved, expenses of dinner meetings of the Council and guests, are to be borne by the HTMA.

There being no further business, the meeting adjourned.

I. L. TILDEN, M.D., *Secretary.*

*In very special cases  
A very superior Brandy*



*Specify*

★ ★ ★  
**HENNESSY**

THE WORLD'S PREFERRED  
COGNAC BRANDY

Schieffelin & Co., New York N. Y.

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 315th regular meeting of the Hawaii County Medical Society was called to order by President T. David Woo at 7:55 p.m. Thursday, December 27, 1951 in the Staff-Room of Hilo Memorial Hospital with the following members present: Drs. M. H. Chang, Fernandez, Hata, Kasamoto, Kutsunai, Miyamoto, Mizuire, Okumoto, Ota, Francis Wong, and Woo. Guests present were Dr. Mary Glover and Dr. Leo Bernstein.

Movies on the "Nutritional Aspects of Tropical Medicine" and "Coarctation of the Aorta" were shown.

The question of contributing \$125.00 for the purchase of a projector was discussed. It was mentioned that the Nurses and the Medical Staff of Hilo Memorial Hospital have already contributed their share. After a short discussion it was agreed to take \$140.00 out of the treasury for the movie projector and screen if the Managing Committee refused the \$140.00 request.

Dr. Richard Hata reported on the status of the Treasury. Delinquent dues were also brought up for discussion . . . and the section of the By-laws concerning delinquent dues was read.

The meeting adjourned at 9:15 p.m.

The 316th regular meeting of the Hawaii County Medical Society was called to order by President T. David Woo at 7:35 p.m. on Thursday, January 31, 1952 in the Staff-Room of Hilo Memorial Hospital with the following members present: Drs. Bergin, M. H. Chang, Crawford, Hata, Higa, Kasamoto, Leslie, Loo, Matsumura, Miyamoto, Mizuire, Okumoto, Orenstein, Seymour, Tomoguchi, Francis Wong, Woo, Yuen, and Steuermann.

Movies entitled *Highlights of the Convention of the American Academy of General Practitioners* (held in 1951 at San Francisco, California), *Tolserol in Rheumatoid Diseases*, and *Atomic Bombing*, were shown prior to the business portion of the meeting.

Application of Dr. James A. Rutherford of Kohala, Hawaii for membership into the Hawaii County Medical Society was referred to the Board of Censors for action.

Dr. Edward Wong, who presented a transfer card from the Honolulu County Medical Society, was admitted into the Society by unanimous vote.

Dr. H. E. Crawford gave a talk on civilian defense, particularly its organization here on this island, in case of a disaster. Discussion then followed.

The 317th regular meeting of the Hawaii County Medical Society was called to order by President T. David Woo at 8:30 p.m. (following a dinner) on Thursday, February 7, 1952 at the Lanai with the following members present: Drs. Brown, M. H. Chang, Crawford, Haraguchi, Higa, Kasamoto, Kutsunai, Leslie, Miyamoto, Okumoto, Orenstein, Ota, Ota, Tomoguchi, Francis Wong, Woo, Yuen, Steuermann, Kaufmann, and Edward Wong. Guests present were Dr. R. B. Cloward and Dr. W. E. Howes.

Dr. James A. Rutherford's application for membership into the Society was accepted unanimously by secret ballot.

Following the business portion of the meeting Dr. R. B. Cloward then gave a very instructive and interesting talk on "Ruptured Intervertebral Disc."

FRANCIS F. C. WONG, M.D.  
Secretary

## HONOLULU COUNTY MEDICAL SOCIETY

On behalf of the Society, the Board of Governors welcomed Lt. Cols. Otto Wurl and Orland Olsen, Lt. Wallace L. Chan, and Capt. John P. Brady (USN) to associate membership.

The January meeting of the Society was held January 4, 1952 at 7:30 p.m. in the Mabel Smyth Auditorium. Dr. William Walsh, Vice President, presided in the absence of Dr. John Wm. Devereux. Approximately 100 members and guests attended.

Dr. John G. Lynn IV presented an interesting paper entitled, "Psychosomatics in Medicine and Surgery." Slides accompanied his talk.

Dr. A. S. Hartwell gave an informative report highlighting the activities of the AMA Convention held in Los Angeles, December 1951.

Upon completion of the scientific program, the Rules and Regulations, Agreement and Application for Participating Physician Membership in the HMSA were circulated. Dr. Walsh stated that the question confronting the membership was whether or not the Medical Society approved entering into a formal participating contract with HMSA.

It was announced that the Board of Governors, after months of detailed study and revision, aided by legal counsel, recommend that the proposed contract be approved by the Society. Dr. Faus stated that the document was not final as it must first obtain HMSA's approval, and that further changes would have to be made in order for the contract to conform to the Constitution and By-laws of HMSA.

After a vigorous discussion, Dr. Devereux moved that the Medical Society go on record as empowering the Board of Governors to negotiate with HMSA, using the Agreement for Participating Physicians as its working principle. By a show of hands, the motion carried almost unanimously.

The meeting adjourned at 10:30 p.m. to refreshments on the Lanai.

A special nonscientific meeting was held on Thursday, January 31, 1952 in the Mabel Smyth Auditorium. Dr. John Devereux presided with approximately 90 members and guests present.

Mr. Joseph Veltman, General Manager of HMSA, discussed "HMSA and Its Place in the Community."

Mr. Jerry L. Pettis, Public Relations Director of the California Medical Association, presented an interesting talk highlighting, "The Situation of Medicine in California at the Present Time" and "Trends of American Medicine during Election Year." Questions and discussion followed.

The meeting adjourned at 10:00 p.m. Refreshments were served on the Lanai.

WILLIAM S. ITO, M.D.  
Secretary



### KAUAI COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital on December 11, 1951 at 7:30 p.m. with Dr. Fujii presiding.

The regular monthly November meeting was cancelled due to the Pan Pacific Surgical Congress in session.

A letter from Dr. A. L. Vasconcellos addressed to the President was read. Since the organization of the new Hawaii Territorial Academy of General Practice, an affiliate of the American Academy of General Practice, the territorial organization has been granted the power by the National Organization to charter any component chapters in the outlying areas that may desire such charter. Any five members in good standing of the American Academy of General Practice may petition for charter in their respective areas. If there are not the required five members in the area, membership application may be made through the Hawaii Territorial Academy of General Practice. Petitions for charters may now be made directly to the Hawaii Territorial Academy. A lengthy discussion followed, and it was finally decided that we await further information from Dr. Maxwell D. Boyd before making any decisions.

Dr. Kuhlman questioned the future set-up of the Kauai branch of the HMSA since Mr. Arthur Achors has severed his connection with the organization. The Society as a whole thought that perhaps Dr. Faus would be kind enough to come and speak to them on this subject. The secretary was asked to communicate with Dr. Faus.

Dr. Peter Kim spoke for the Nurses Organization on behalf of the Disaster Council regarding two speakers who are to appear sometime in February: Mr. Burns and Dr. Paskowitz. The Society was asked to sponsor this program jointly with the Nurses' Organization and the Society sanctioned approval.

The speakers of the evening were Dr. Quisenberry and Dr. Deibert, who spoke on "Chronic Diseases."

Subjects covered were: Plan for Chronic Diseases, A.M.A. Commission in Chronic Diseases, The Chronic Illness Advisory Committee in Hawaii, Heart Disease Program, Rheumatic Fever Unit of Children's Hospital, Professional and Lay Education, Diabetic Detection Centers, and Federal Aid to Medical and Dental Schools.

In conclusion, Dr. Quisenberry mentioned that no new cases of cancer have been detected by Mrs. Huddy, our cytology technician, and that not many specimens are being received for examination.

He spoke on the possibility of getting services at the virus laboratory at Tripler Hospital.

Next mentioned was Mrs. Hee with her V.D. cases—the difficulty encountered in finding contacts.

A movie titled "Be Your Age" was shown.

The regular meeting of the Kauai County Medical Society was called to order by President K. Fujii at 7:40 p.m. Wednesday, January 9, 1952 at the G. N. Wilcox Memorial Hospital.

Members present were: Drs. Cockett, Wade, Goodhue, Masunaga, Kuhlman, Kim, Boyden, Fujii, and Ishii.

Speakers for the evening were Drs. Faus and Boyd and Mr. Veltman. Mrs. Inouye, supervisor for the Kauai

branch of the HMSA, and Dr. Y. Kim, resident physician, were also present.

Both Dr. Faus and Mr. Veltman spoke on HMSA.

Dr. Boyd presented details regarding the examination of inductees and the problems encountered, with particular emphasis on the monthly expenditure incurred. Examination of inductees locally instead of at Tripler Army Hospital was requested. After a lengthy discussion by the members of the Society, it was voted that the inductees be examined at Tripler Army Hospital as in the past for the best interest of the inductees and the service.

Dr. Boyd, Executive Secretary of the American Academy of General Practice, recommended that the outlying counties form their own chapters. After some discussion the members decided to form an opinion at the next meeting of the Society.

CLYDE S. ISHII, M.D.  
Secretary

### MAUI COUNTY MEDICAL SOCIETY

A business meeting of the Maui County Medical Society was held at the Maui Grand Hotel on Tuesday, December 18, 1951 with President Edward Shimokawa presiding. Members present were: Drs. Fleming, Ferkan, Burden, Tompkins, Underwood, Lathrop, Shimokawa, Kanda, St. Sure, Tofukuji and Wong.

Dr. St. Sure brought up the question of drawing blood for alcoholic content with reference to Act 283, Session Laws of Hawaii, particularly Section 11723. He stated that he had written to the Attorney General two years ago but has not received a satisfactory answer. He also read a letter by Nathaniel Felzer, Deputy City and County Attorney to Dr. Mossman in 1949. Another letter from Dr. Alvin Majoska was read. A final letter by one of our local attorneys hired by H.C.&S. Company expressed opinions in agreement with those of Nathaniel Felzer. He feels that permission in writing should be obtained from the individual from whom blood is to be withdrawn and duly witnessed.

Dr. Lathrop showed T.B. posters in conjunction with mobile unit schedule. He asked doctors to post same at their office in an effort to get people to have their chests x-rayed.

Dr. Lathrop announced that as of January 1, 1952, he will be county registrar. Four deputy registrars will be appointed in view of isolated areas. They will be located at Lanai, Hana, Lahaina and Molokai.

Dr. Lathrop reminded that all government doctors are obliged to take care of D.P.W. and medical indigent cases as specified by Act 129. Cases should be hospitalized, if necessary, in hospitals where M.D.'s practice. He also mentioned Act 129 will take care of expensive drugs if patients receive them as out-patients. X-rays of out-patients taken only at approved hospitals, will be reimbursed by Act 129.

Dr. L. Vasconcellos, president of the Territorial Academy of General Practitioners, urged the formation of our own chapter to the Academy. Dues are \$10.00. For information to interested applicants the initiation fee to the national organization is \$10.00. Annual dues are \$15.00.

Films on Gelfoam and Heparin treatment in surgery were shown by Dr. Lathrop.

A. Y. WONG, M.D.  
Secretary, pro tem

# NOTES AND NEWS

## PERSONALS

New diplomates of the American Board of Orthopedic Surgery include **Dr. T. Alan Casey**, **Dr. Richard S. Dodge**, **Dr. Ivar J. Larsen**, **Dr. B. Allen Richardson** and **Dr. John W. Cooper**, all of Honolulu.

**Dr. Lucy Ma**, wife of **Dr. Koon Sun Fong**, has opened her office at 483 South Beretania Street, Honolulu, for the practice of obstetrics and gynecology. Dr. Ma is a graduate of Cheeloo University Medical School in China and has had medical training, internship, and postgraduate work in obstetrics and gynecology at the Margaret Hague Memorial Hospital in Jersey City. She has lived in Honolulu since 1946 and has been licensed to practice in Hawaii since 1950.

**Dr. Richard W. You** has been appointed a member of the official United States Olympic Party and will accompany the U. S. Team to Helsinki, Finland for the 1952 Olympic Games. He will join the U. S. Olympic party in New York in June.

**Dr. Clive Robinson**, dermatologist from Sydney, Australia, visited Honolulu in February on his way home from a world tour.

**Dr. William S. Reveno** of Detroit, Associate Professor of Medicine at Wayne University and author of the recently published "711 Medical Maxims," visited Honolulu with his wife in February. He gave a talk on thyroid disease before the Straub Clinic staff.

**Dr. Samuel Yee** has recently been appointed chairman of the Public Health Committee of the Honolulu Chamber of Commerce.

**Dr. Richard Siu Fun Lam**, assistant surgical resident at Queen's Hospital, married Miss Lani K. N. Chun at St. Patrick's Church in Kaimuki on December 9, 1951.

Suzanne Spencer, attractive daughter of **Dr. and Mrs. Frank Spencer**, became the wife of Don Reed Lord on January 25, at St. Andrew's Cathedral.

**Dr. and Mrs. Morton Berk** became the parents of their third child and second boy, named Scott Marshall, on December 10, 1951.

The Secretary of the Territorial Medical Association has on file a large number of applicants who would like to work in physicians' offices. The applicants include nurses' helpers, bookkeepers, stenographers, and receptionists. Further information regarding these applicants may be obtained from Mrs. Bennett at the Mabel Smyth Building.

**Dr. Harold M. Sexton**, formerly of Hilo and Honolulu, has been appointed chief resident at the East Bay Children's Hospital, Oakland, California.

**Dr. Thomas Min** has been elected President of the Korean University Club. **Dr. Richard You** has been elected Vice-President of the same organization.

**Dr. Archie Chun-Ming** announces his return from the mainland and the opening of his office, limited to diseases of allergy, at 1231 Beretania. Dr. Chun-Ming is a former President of the Reserve Officers' Association, Department of Hawaii.

**Dr. Paul Withington** was reappointed chairman of the Territorial Boxing Commission for the term ending December 31, 1956.

**Dr. Richard You** was elected President of the Kamaaina Magic Circle and also "Sportsman of the Year."

**Dr. Robert Hunter** has returned from a three months stay on the mainland. While away, Dr. Hunter was instructor in the Department of Obstetrics and Gynecology at the Charity Hospital, Tulane University, New Orleans.

The Queen's Hospital announces the addition of **Dr. Robert D. Browne** to its resident staff. Dr. Browne graduated from Johns Hopkins University in 1950. He served a previous internship at the Harriet Lane pediatrics unit of Johns Hopkins U. For the past few months, he has been employed by the Hawaiian Pineapple Company in a research capacity. He replaces **Dr. Gilbert Ching**, who is a patient at Leahi Hospital.

**Dr. and Mrs. Clarence Wyatt** announce the arrival of their fourth daughter, Christine, born December 12, 1951.

**Dr. Jacob Ing** has been elected President of the Chinese University Club for 1952.

**Dr. Fred Lam** was elected President of the Chinese Chamber of Commerce for 1952. Dr. Lam was also general chairman for the recently held Narcissus Queen Festival.

**Dr. Nils P. Larsen** was the principal speaker at the "Know Your Hawaii" series at the YWCA on the subject of "Hawaiian Medicine."

**Lt. Rawlin L. Lichter**, former intern at St. Francis Hospital, son of **Dr. Martin H. Lichter**, graduated from the Air Force School of Aviation Medicine at Randolph Field, Texas.

**Dr. F. F. Alsup** returned to Honolulu following a brief visit to the mainland.

**Dr. Charles L. Wilbar, Jr.**, President of the Territorial Board of Health, was elected President of the State and Provincial Health Authorities Association of North America for 1952.

**Dr. and Mrs. Shoyei Yamauchi** and their 16 year old son were active participators in the Christmas Festivities presented by the Kaimuki Community Council entitled "The Other Wise Man."

**Dr. George F. Straub**, kamaaina physician and founder of The Clinic, has been the inspiration for the physicians now comprising The Clinic to rename their group the "Straub Clinic." "The Clinic is dead, long live the Straub Clinic."

**Dr. Katherine Jean Edgar** has been appointed assistant chief of the Bureau of Maternal and Child Health and Crippled Children. Dr. Edgar is a graduate of the University of Oregon medical school and has been in private practice for 15 years in Bridgeport, Connecticut.

St. Francis Hospital announces the appointment of **Dr. Richard D. Moore** as Director of the Radiology Department. Dr. Moore assumed his duties February 5.

Dr. Moore is a graduate of Jefferson Medical College, Philadelphia. He served his internship at Bryn Mawr Hospital, Pennsylvania. Following one year's residency in internal medicine at Wisconsin General Hospital in Madison, Wisconsin, he served two years in the United States Army. Dr. Moore then spent two years as a



resident in radiology at the Graduate Hospital of the University of Pennsylvania. For the past two years he has been Associate Radiologist of the Graduate Hospital, and instructor of Radiology in the Graduate School of Medicine of the University of Pennsylvania.

A Diplomate of the American Board of Radiology, Dr. Moore is also a member of the American College of Radiology.

**Dr. Clifford Moran**, Pathologist of St. Francis Hospital, has resigned to return to the mainland. His professional abilities and interest in research have contributed greatly to the progress of his department during his service at the hospital. Dr. Moran will be replaced by a full-time pathologist whose appointment will be announced at a later date. Dr. and Mrs. Moran left on the President Polk for New York by way of the Far East.

#### Corrigendum

**Dr. Vernon K. S. Jim** is undertaking residency training in ophthalmology at Billings Hospital in Chicago, in-

stead of a post-graduate course as was announced in our November-December issue. After July 1 he will continue his residency training in ophthalmology at Cook County Hospital in Chicago.

#### Hawaii

**Dr. and Mrs. Walter S. L. Loo** welcomed a new son on Feb. 6, 1952. His initial fighting weight was 7 lbs. 13 ounces.

Since the beginning of the year, **Dr. William E. Howes**, formerly of Great Neck, N. Y., has joined the professional staff of the Hilo Memorial Hospital. Dr. Howes is a diplomate of the American Board of Radiology and a fellow of the American College of Radiology. He is a member of the American Roentgen Ray Society, Radiological Society of North America, American Radium, New York Roentgen Society, and the Phi Chi honorary Radiological Society. He had been the director and attending radiologist of the Brooklyn Cancer Institute in New York from 1944 to Dec., 1951. During the past 15 years, he has also been the radiologist at the Carson C. Peck Memorial Hospital and the Lutheran Hospital in New York. Dr. Howes is married and has 3 children. He was a Lieutenant Commander in the U. S. Navy.

**Dr. Robert Miyamoto** was recently appointed a member of the Public Lands Commission from the Big Island by Governor Long.

#### Kauai

**Dr. William Goodhue** of Eleele, Kauai vacationed on the Big Island in February. During his sojourn there, he met and discussed "old times" with former associate, **Dr. Nicholas Steuerman**.

#### NEWS

##### Hawaii Diet Manual Revision

The Diet Therapy Committee of the Hawaii Dietetic Association, under the chairmanship of Miss Fujino Nikaido, Chief Dietitian Kapiolani Hospital, is in the process of revising The Hawaii Diet Manual for a reprinting this next summer.

There will be a revision of the Diabetic Calculations. This revision will comply with the tables as listed in the publication entitled "Meal Planning with Exchange Lists" which was compiled by Committees of the American Diabetic Association and the American Dietetic Association in cooperation with the Diabetes Branch, Public Health Service, Federal Security Agency.

Doctors who have recommendations and suggestion for the revision please contact the hospital dietitians in Honolulu.

It is hoped that the new Manual will be off the press by September 1, 1952.

##### Kapiolani Hospital

Outpatient Clinic service has been established as of September 1951 at the Kapiolani Maternity and Gynecological Hospital. **Dr. H. E. Bowles** is acting consultant obstetrician and Mrs. Tamako Ito, R.N., is in charge of the clinic. It is staffed by the four resident doctors, and operates daily. Initial antepartum visits are scheduled on Thursdays. This service was formerly rendered by the Territorial Health Department.

#### ROBERT AKIO KIMURA, M.D.

1897 — 1952

Dr. Robert Kimura, past President of the Japanese Medical Society and currently President of the Kuakini Hospital Medical Staff, the Japanese Civic Organization and the Japanese Rowing Club, died of hepatic carcinoma on January 31, 1952, after an illness of less than six months.

Born in Yamaguchi Prefecture in Japan on December 15, 1897, Dr. Kimura came to Hawaii with his parents in 1899. He graduated from McKinley High School in 1919, and, after a year at the University of Michigan, from St. Louis Medical School in Missouri in 1927.

In 1928 he took postgraduate work at Tokyo Imperial Hospital, and while there married Mrs. Kimura. The following year he resumed practice in Hawaii. From 1941 to 1946 his practice was interrupted by his internment at Crystal City, Texas.

Dr. Kimura's career was distinguished by frankness and sincerity and by a spirit of conscientious service to the whole community. In addition to the offices mentioned above, he was a member of the Board of Directors of the old Pacific Bank and the Honolulu Fire Insurance Company, and of the Japanese Chamber of Commerce. His hobbies were principally contract bridge, baseball, and the raising of orchids.

He is survived by his wife Fusako and by three sons, Chris, 16, Herbert, 15, and Stanley, 11.

Dr. Kimura's courage, stamina, and desire to work for his family to the very last were marvelled at by all who knew him. He accepted the responsibility of the presidency of the Kuakini Hospital staff, at a crucial period in the institution's existence, after he knew the nature of his illness. The medical profession may well be proud to have numbered such a man among its ranks, and it is the poorer for his untimely loss.

# UMI MAKAHIKI I HALA\*

## NEW MEMBERS

Maui County:

**Wm. W. Wilkinson**, Lanai City, Lanai.  
**Lewis S. Shapiro**, Pukoo, Molokai.  
**Douglas Murray**, Paia, Maui.  
**Hawley H. Seiler**, Paia, Maui.

## PERSONALS

**Dr. Brennecke** has left Koloa to become director of medical affairs at Kekaha and Waimea, on Kauai.

**Dr. Beck** left Kealia to replace Dr. Brennecke at Koloa and, for the present at least, **Dr. Sam Wallis** has taken over Dr. Beck's work.

**Dr. Alfred Burden** has been called into the Army and has recently left for the Coast for a period of training.

**Drs. Doug. Murray, Tom Cowan, Al Burden and Jim Fleming** all from Maui are now in the service. **Dr. Anderson** expects to be called soon.

**Dr. John Sanders**, who has been doing survey work at

\* Ten years ago. From Volume 1, Number 4, March-April, 1942.

Kula Sanitarium, will be with the Paia Hospital in the future.

**Dr. Steele Stewart** has just arrived from Los Angeles to take over the Shriners' Hospital. In 1939 Dr. Stewart lectured to the Society here on orthopedics. He is a graduate of Penn, 1918.

**Dr. R. B. Cloward** has the distinction of having the first article on war experiences in Hawaii appear in a mainland Journal. The January 24 issue of the A.M.A. carried his paper on "War Injuries of the Head," and a subsequent issue of *Time* commented extensively upon it.

**Dr. "Pete" Halford** had a record attendance of doctors and nurses for his recent Sunday morning lecture on the treatment of burns.

**Dr. Harold Sexton**, house doctor at Queen's, and Miss Audrey Boyton of Oakland, California, were married on Sunday, March 15, at the home of his parents, **Dr. and Mrs. L. Sexton** in Hilo.

**Dr. Ernestine Hamre** spent two weeks on Hawaii at the request of Medical Preparedness Committee to give instructions in first aid.

## CORRESPONDENCE

### CATASTROPHIC HEALTH INSURANCE

TO THE EDITOR:

I am wholeheartedly in agreement with the JOURNAL's recent editorial strictures concerning the HMSA's persistent attempt to insure the uninsurable. While a large number of people have climbed onto its bandwagon, the poor old wagon is still wallowing in the slough of office and house calls rather than rolling on the tried highway of catastrophic illness.

I agree that some form of deductible insurance is probably the answer to much of the economic bugaboo of hospitalizing sickness. However, before doctors get too involved in any plan, it might be interesting to look at a few facts.

Some time ago I made two surveys of the bills of patients discharged from a local hospital in 1946 and 1948, with almost identical results. There have been no great changes in hospital bills in the past four years. The 1948 survey covered 3,591 discharges in a period of about three months. It showed

Minimum bill—\$10.  
Maximum bill—\$5,225.  
The average bill was \$121.  
The median person paid \$80-\$85.  
The median amount paid was \$160-\$165.  
The largest single group of bills was \$40-\$45.  
6.94% of patients paid a bill in excess of \$300.  
13.95% of patients paid bills in excess of \$200.

When the mass of statistics was analyzed it was found, assuming that one person in eight was hospitalized each year (actually it was one in twelve for the nation), that it would have cost the community \$1.26 per person per month to give full coverage, for hospital bills only, up to \$5,000. If \$100 deductible per illness were introduced, the cost would be \$.495 per month. This figure does not include any provision for

operating expenses of the insuring agency nor any reserves.

As we all know, the only major variables in hospital costs to the patient are: the period of hospitalization, and the three types of hospital accommodation. The use of private rooms would be limited by the structural arrangement of the hospital; the period of hospitalization would be determined by the character of the illness.

However, when one comes to insuring hospitalizing illness covering hospital, doctor and nursing bills, one is up against two uninsurable risks, the cupidity of the doctor and the desire of some patients for luxury nursing.

It is frequently assumed that the physician's bill should equal the hospital bill. If such an assumption were true, and I doubt it, the policy that proposes a \$300 deductible would pay something toward the bills of more than median size and would pay nothing for well over 77% of hospitalizing illness.

In our present economy, where wages and living costs dog-and-cat one another so closely, I feel the average person would find a \$300 deductible illness policy rather cold comfort. It is my opinion that a spate of policies with lesser deductions would be much more attractive, although their cost would pyramid as the deductions fell.

Therefore, from the patient's standpoint the proposed insurance offers little. From the standpoint of the insurer, unless there are adequate safeguards against professional avarice and the desire of patients for unnecessary pampering, the proposed insurance will prove a grave risk.

STEELE F. STEWART, M.D.



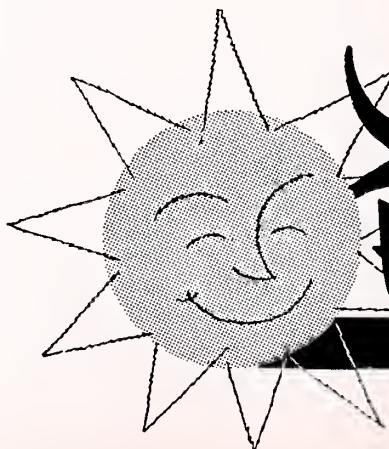
# WHAT IS HINODE FORTIFIED RICE?

## WHAT IS HINODE FORTIFIED RICE?

Many patients who are habitual users of ordinary white rice are asking this question. The principle of "enrichment" or "fortification" by returning to foods certain nutrients which had been removed in processing has been accepted by the National Research Council.

Now available in Hawaii for the first time, 8 ounces of Hinode Fortified Rice furnishes 100% of the minimum daily adult requirements of thiamin, at least 8 mg. of niacin, and 65% of the minimum daily requirement of iron in the form of ferric-pyrophosphate. In most cases Hinode Fortified Rice is the answer in raising nutritional levels for the people of Hawaii. Certainly, no one can doubt that this may make a vast difference in the health and welfare of many families.

**Rice Growers Association of California**  
**Macdonald & Porter, Honolulu — Territorial Agents**



# HINODE

## FORTIFIED RICE

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

---

LEONA R. ADAM, *Executive Secretary*, Honolulu

## BULLETIN COMMITTEE

CLAIRE CANFIELD, *Editor*, Board of Health, Honolulu

LORETTA SCHULER, *Nursing Information Committee*, ARC, Honolulu

JUNE APO, Honolulu

ALICE SCOTT, Honolulu

MARJORIE ELLIOTT, Honolulu

MARGARET BARNETT, Hawaii, *Secretary*

JOANN GROBERG, Maui, *Secretary*

MYRNA CAMPBELL, Kauai, *Secretary*

GLADYS LEONG, Oahu, *Secretary*

---

## GROUP TEACHING OF DIABETIC PATIENTS IN HAWAII

ELEANOR MATSUMOTO and MARJORIE ABEL\*

Group teaching is being used more and more in many aspects of health education. It is always supplemented by individual conferences for special problems. Many aspects of a problem are common to all people involved and people seem to derive comfort and strength from knowing that others share their problem. Group therapy was established by psychiatry during World War II. Group discussions for the obese have been very successful in Boston. The American Diabetic Association, the American Dietetic Association and the U. S. Public Health Service have worked jointly in preparing simplified teaching materials in diabetes. A part of this program was the preparation of a kit for teaching groups of diabetic patients.

This Diabetic Kit consists of eleven film strips with accompanying records, instructors' guides, and wall charts, in a compact carrying case. The subjects covered include: What is Diabetes; Insulin and Its Use; Insulin Reaction; Tests in Diabetes; Diabetic Coma; Care of Your Feet, and five film strips on planning, buying, cooking and selection of food.

Diabetes mellitus is increasing in importance as a health problem in Hawaii as on the mainland. It did not appear at all among the leading causes of death in 1930. By 1950, it was eighth of the ten leading causes of death, with 88 deaths from diabetes reported. The rate was

19 per 100,000 population. Most of these deaths were in the older age group.

The first series of classes using the Diabetic Kit in Hawaii was in the Dispensary of the Oahu Sugar Company on Oahu. There was a group of 24 diabetic patients coming to the dispensary regularly for tests and insulin. Many of these were being followed in the home by public health nurses. At the suggestion of one of the public health nurses, the possibility of group teaching for these patients was discussed with the plantation physician, the county nutritionist and the laboratory technician. Two patients, who were community leaders, attended the preliminary planning meeting.

Twenty-four attended the first group discussion and twenty-two continued to attend fairly regularly. The racial distribution was interesting: 8 Filipinos, 10 Japanese, 1 Chinese and her Chinese-Portuguese daughter, and 1 Portuguese.

One or more filmstrips were shown at the beginning of each session and the questions at the end of each strip were used to stimulate discussion. Participation was surprisingly good even though language was a handicap for 3 Filipinos and the 10 Japanese. The patients did not want separate sessions. They felt that they would be left out of something. A public health nurse interpreted for the Japanese and one of the patients interpreted for the Filipinos. Mrs. R., a Filipino patient, had been rather uncooperative but when she began to participate her whole attitude changed. Discussion was continued outside of the group, while waiting at the dis-

\* Chief Nutritionist and Chief, respectively, Bureau of Nutrition, Department of Health.



pensary or for conferences with the nutritionist. One patient who had seemed most uninterested was overheard instructing others on the very points where he had failed.

An important part of the whole project was the keeping of diet records by each patient for at least one week. The record blanks were explained and distributed at the first session. The diet records were reviewed by the physicians as well as by the nurses and the nutritionist. The nutritionist had an individual conference with each patient to discuss these records. As was expected, the first set were not very accurate. Careful questioning by the nutritionist during the conference helped correct some of these inaccuracies. A diet plan was made for each patient at this interview. Diets were planned, using Exchange lists, which are a part of the entire teaching plan. The lists were adapted to Filipino and Japanese foods and were mimeographed. The patients found their diets much more satisfying when they were able to include some of their own racial foods.

The most obvious dietary faults noted on these first records were:

- Irregularity of eating habits
- Wide variation in caloric intake
- Failure to include one or more food groups regularly which resulted in dietary deficiencies.

Sixteen patients attended the sessions regularly. Most of those who dropped out had valid reasons and some of these are being followed in the homes. These sixteen patients kept a second diet record and two have kept a third record. All but one of these showed improvement in dietary practices which were substantiated by laboratory tests and needed adjustment in the amount of insulin used. Two patients were slightly obese and have actually lost some weight on their adjusted diets. One patient, who was also an arrested tuberculosis patient, gained weight and was pleased that adjustment of her insulin intake made this possible.

The need for periodic follow-up is recognized and more sessions have been requested by the patients themselves. Two neighbors were brought to one follow-up session. Wives, or those family members who do the buying and cooking, should attend. This was brought home forcibly by one patient who said "I go ice box to get fruit for breakfast. No stop. My wife she no buy."

All of these patients had been under care for years, with every effort to teach them individually about their disease. Yet the group discussion gave the opportunity to ask questions such as these:

1. Can a diabetic obtain a life insurance policy?
2. Does bread have less calories than rice?
3. How can I have my family tested for diabetes?
4. Is it important for me to have my insulin injections daily?
5. What makes me feel hungry and nervous at times?
6. Can I drink milk?

Everyone involved in the project feels that it has been very worthwhile. The patients seem to have a better understanding of their disease. Food habits of many showed real improvement. The families of some have been tested for diabetes.

#### Case Comments

Mrs. S. is over 80 yet was one of the most interested and enthusiastic members of the group. She does not speak or write English and kept her diet records in Japanese. Her usual breakfast on the original record was three slices of bread, lettuce and tomato salad and coffee. She had once heard that vegetable salads were good for diabetics. She reduced her bread to one slice at breakfast by the third week of the series and has cut her rice consumption in half. She has added fruit and an egg to her regular breakfast. She is still eating her salad but is now having it at lunch. She continues to use her Japanese dishes but meals are more complete and she is using some milk.

Mr. D. was several pounds overweight and ate very irregularly. He had continually changed doctors and was not following any advice. His understanding of diabetes was so poor that he ate six doughnuts as soon as he finished his first week's diet record. His urinalysis was definitely out of line with his diet record the next day. He readily admitted the doughnuts but said "I finish my record. I feel weak so I eat six doughnuts." Sessions with him were often stormy. When told he could use two cups of milk daily, he began using four or more. He made radical changes, then dropped them all to return to his original habits. During the week when he kept his second record he ate a good varied diet with decreased bread and rice, increased fruit, vegetables and proteins. He was sure he had lost weight and was surprised to find he had actually gained. Mr. D. needs continuous follow-up but there is evidence that he is learning. For one thing, his attendance is more regular. For another, he now feels himself an authority and has been overheard coaching other patients during informal discussions while they are waiting.

#### STANDARD SCORES AND STATE BOARD TEST POOL EXAMINATIONS

SISTER MARY ALBERT, R.N., O.S.F.

What's in a test score? That's a difficult question to answer. Not only is there considerable statistical vocabulary (from which most people shy away) involved, but much depends upon the type of score used in addition to the validity and reliability of the test administered. Many of us have taken, or will take sometime in our lives, various tests, the results of which are reported in

the form of scores of one type or another. This article may help to give the reader some understanding of the "standard score" which is employed by the National League of Nursing Education to report achievement on the State Board Test Pool examinations.

The Board for the Licensing of Nurses, Territory of Hawaii, joined the State Board Test Pool in 1946, not many years after it was inaugurated. Today all 48 States, in addition to the District of Columbia, the Territory of Hawaii and the Province of British Columbia, participate in the testing program.<sup>1</sup>

The League has not always used the standard score in reporting test results. In fact, up until recently, theoretical percentage scores were used. They were discontinued because of several major discrepancies. Their units were not equal and each set of theoretical percentages was based upon a single jurisdiction.<sup>2</sup> In other words, the same percentage of students in each State or Territory were failed, regardless of how high or how low the State average was. In the case of the Territory of Hawaii and comparable States, whose candidates for licensure ranked around the 15% of candidates all over the country, this method was not found feasible. In addition to its conferring failing marks on candidates whose scores compared very favorably with Mainland candidates who were passed, it provided far too little difference between passing and failing raw scores since so many scores were cluttered around a relatively small range. Before the subject matter of the State Board Test Pool examinations was intergrated, applicants tried as many as twelve examinations, on each one of which, according to this system, 7% of Territorial applicants would be assigned a failing grade.

Standard scores are much more reliable than raw scores, percentile scores and theoretical percentage scores. They also have many other advantages such as the ability to be compared and averaged.<sup>2</sup> In simple terminology, standard scores are arrived at by:

1. Obtaining raw scores (the number of items in a test answered correctly) for a large representative group of individuals. This constitutes the standardization group.
2. Computing the average (or mean) score.
3. Computing and squaring the difference between each individual score and the mean score.
4. Averaging the squares of these differences (or deviations) and then taking the square root of

the average. This gives what is called the standard deviation.

5. Making one standard deviation equal exactly 100 standard score points and assigning the value of 500 points to the mean score of the standardization group.
6. Adding or subtracting 100 points from 500 for each standard deviation that the applicant's score falls above or below the average score of the standardization group. Thus if the average raw score of the national group on a specific test is 100 and the average deviation for the test is 15, a candidate receiving a raw score of 130 would be given a standard score of 700 or a letter grade of "A" by the Board for the Licensing of Nurses, Territory of Hawaii.

The following is the table used by the local licensing board for translating standard scores on a national basis into letter grades for graduates taking Test Pool examinations in Hawaii.

- A standard score of 650 = lowest limit of A or 6.7% of all cases
- A standard score of 550 = lowest limit of B or 24.2% of all cases
- A standard score of 450 = lowest limit of C or 38.2% of all cases
- A standard score of 350 = lowest limit of D or 24.2% of all cases
- A standard score of below 350 = failure or 6.7% of all cases

With this information available, the candidate for licensure can readily see that if she receives an "A" in a certain subject, her grade is higher than 93% of all candidates taking the test; that if she receives a "B", she has a better grade than 69% of the candidates; a "C" would show that she ranked in the middle 38%; a "D" would mean that her grade was better than only 31% of the applicants and an "F" would show her score to be among the lowest 7%.

It is a well known fact that the over-all record made by graduates of Island schools of nursing on State Board Test Pool examinations from the time they were first used in Hawaii is highly gratifying. However, specific data for only the St. Francis Hospital School of Nursing is available to the writer. It is a pleasure to report that 98% of the 176 nurses who graduated from St. Francis and took State Board Test Pool examinations for the first time within the last five-year period made a passing standard score on all 5 to 12 licensing tests taken. Only 2% failed one test each. No graduate failed more than one test.

This is an enviable record and the Islands can be proud of the reputation local graduates are making for themselves. It is hoped that, with the help of God, the accomplishments of the future will be just as noteworthy or even more outstanding.

<sup>1</sup> Fifty-seventh Annual Report of the National League of Nursing Education. New York, N.L.N.E., 1951, p. 143.

<sup>2</sup> National League of Nursing Education, Department of Measurement and Guidance. The "Why," "What," and "How" of Standard Scores. New York, N.L.N.E., 1951.



### NEWS FROM "DOWN UNDER"

Miss Laura Draper, who resigned as Chief of the Bureau of Public Health nursing, Territorial Department of Health, on January 4, left Honolulu shortly after to attend the Pan-Pacific Women's Conference held at Christchurch, New Zealand, January 11-25. She is presently touring the island, and plans a stop-over in Honolulu en route to Phoenix, Arizona late in March. It is a privilege to share with readers of the bulletin and friends of Miss Draper the following descriptive material enclosed in a recent letter.

Christchurch, New Zealand  
January 19, 1952

"The flight down was delightful, about twelve hours from Honolulu to Fiji where we changed planes, about eight hours more to Auckland where we spent the night, and finally a four hour flight to Christchurch. It doesn't seem at all far away.

"The Pan-Pacific Women's Conference is now in full swing, with delegates from twenty countries. UNESCO paid the fare in part for the nine delegates from Asian countries, and as a result photographers are having a field day taking Burmese, Indonesian, Filipino, Japanese, Vietnamese, Cambodian, etc. costumes. Such exotic apparitions don't often appear in Christchurch, I judge. It adds much to the conference, too, to have representatives from these countries which are in such a state of transition and growth, and they are making good contributions.

"I can well believe that Christchurch is more English than England, just as I had heard. Almost every house, perhaps every house, has a little or big garden, and there is the gayest profusion of "mainland" flowers—huge roses, snapdragon, delphinium, almost any flower that grows in northern states at home. When the pioneers came a hundred years ago, they found a muddy little river, and promptly named it, Avon. It is no longer muddy, curves through the town, weeping willows and poplars bordering it, and ducks and sea gulls furnishing appropriate fauna (or do they?).

"We are kept very busy between study sessions and sightseeing. Today is: 'All day trip to see farm lands. Lunch at Lincoln University Agricultural College. Afternoon Tea at "Longbeach" (a private home). Tea at Ashburton.' Apparently two teas, and always too delicious to be refused.

"The weather has been pretty chilly; the newspaper reported 44.6 'on the grass.' Cold, anyway. I looked for the Southern Cross and there it was 'way up in the middle of sky, but what else there was I didn't find out in my hasty dash to get out of the wind.

"One night a group of Maori women came in to entertain us. Some were delegates, some live in Christchurch, etc. Anyhow their performance was practically unrehearsed and had the entertaining zest and spontaneity of the famous Canfield-MacBride hula so well known in Hawaii. The leader was a regular Hilo Hattie, and the dances on the energetic rather than the languorously beguiling side. One dancer invited me to come and stay with her when I get to her part of the North Island. Real Hawaiian hospitality!

"I have been trying to find out the current infant mortality, and finally was told by a newspaper woman that she had called the Plunkett Society, and been told

it is 1.6%. (That is the way they give it.) I am amazed, and am going to do my best to see whether it is that they have no premature births or perhaps that they save them all. They don't use incubators, say they can't afford them. On a trip to the public hospital I saw a three pounder with a bonnet—and they explained—a padded premie jacket! He was propped up a little in an ordinary crib.

"Yesterday the Registered Nurses' Association of Canterbury (the district where we are) had luncheon, about forty present. For Esther Stubblefield's delectation I would like to add that the nurses from Thailand, Cambodia, and I were the only women present without hats or gloves! The hostesses no doubt attributed this to our quaint customs. Anyway they were ever so cordial, and I learned quite a bit about public health nursing here. "Everything is going beautifully. Aloha to all friends."

### DISASTER NURSING INSTITUTE

The Hawaii District Nurses' Association reports that the Institute on Nursing in Atomic Warfare, held in Hilo January 31-February 2, has aroused much enthusiasm for preparedness for disaster. Twenty nurses indicated their desire to prepare to teach home nursing. The Red Cross will plan for instructors courses for these nurses.

The following program was given in the very adequate auditorium of the new Puumaile Hospital:

*Thursday, January 31, 7:00 p.m.*

Nature and Effects of Atomic Bomb Disaster—  
Virginia Jones

Blast Injuries—Dr. John Jenkin

Burns—Nature and Care—Dr. Grant Stemmermann

*Friday, February 1, 7:00 p.m.*

Radiation—Detection and Contamination—

Dr. W. E. Howes

Radiation Injuries—Dr. W. E. Howes

Radiation—Public Health Aspects—

Francis W. Woo, Acting County Health Officer  
Organization for Local Defense—

Dr. Howard Crawford

Nursing Functions and Responsibilities—

Mrs. Rosie Chang

*Saturday, February 2, 7:00 p.m.*

Standing Orders for Nurses—Mrs. Rosie Chang

Demonstration of Nursing Technics—

Mrs. Rosie Chang

Plans for Follow-up Practice—Virginia Jones

Army films showing the effects of the atomic bomb and organization of resource services were shown.

Mrs. Edna Baldwin, industrial nurse at Pepee-keo Plantation as chairman of the Nurses' Association Committee presided. Mrs. Ota was chairman of the committee to arrange for demonstrations and follow-up. Thanks must also go to Miss Eunice Graham, supervisor of nurses at Puumaile Hospital, to Mrs. Mae Marcallino, President of Hawaii District Nurses' Association, and to Miss Mary Jean MacDonald, Chief Nurse, Hawaii Department of Health.

The attendance at each of the meetings was about 150 professional and practical nurses. A special meeting was held for practical nurses at which 35 were present.

Kauai District Nurses' Association reports that they are planning for a similar institute in mid-March.

### NURSING SERVICE STUDY

A study to determine the amount and kind of nursing services required to meet minimum public health nursing needs in local health departments will be made by the U. S. Public Health Service. Dr. Marion Ferguson has just been assigned to the Division of Public Health Nursing as director of the study.

The acute shortage of all types of nursing personnel, particularly public health nursing personnel, is the reason for the study, Dr. Ferguson stated.

The study will endeavor to find the answers to such basic questions as (1) the amount of additional nursing service required in the rapidly expanding defense areas; (2) how the available nursing supply can be "stretched" to meet growing needs; and (3) the use of practical nurses or other aides in public health programs.

In commenting on the personnel shortage, Dr. Ferguson said: "There is a limit to the number of women who can be recruited for nursing because of the opportunities now open to women in other fields of work. At the same time the demands for more nursing service in a variety of programs have increased tremendously.

"The presently accepted ratio of one public health nurse for every 5,000 population for the usual preventive health services would require an additional 17,500 nurses right now. With health departments placing increased emphasis on the care of the chronic and aging patients who will require more actual nursing care in their homes, the ratio of one nurse to 2,000 population may be required. To reach such a ratio, the immediate shortage would mount to 40,000 or 50,000."

Dr. Ferguson pointed out that according to the 1951 Census of Public Health Nurses there are still 669 counties with no nurses engaged in full time public health work in rural areas. In thirteen cities with a population of 10,000 or more, there are no nurses engaged in full time public health work, she added.

Dr. Ferguson comes to her new assignment from the Division of State Grants, where she

has been conducting studies of health officer functions for the last two years. A graduate of Peabody College, Dr. Ferguson received both her M.A. and her Ph.D. degrees from Columbia University. She took her basic training at St. Thomas School of Nursing, Nashville, Tennessee.

### BOOK REVIEW

#### Rehabilitation Nursing

By Alice B. Morrissey, B.S., R.N., 299 pp., Price \$5.00, G. P. Putnam's Sons, 1951.

The goal of modern rehabilitation is optimal physical, mental, social, economic and vocational adjustment and usefulness of the handicapped person. The special attributes of many people are required to satisfy the fundamental needs of the individual. Physicians; nurses; medical social workers; physical, occupational and speech therapists; psychologists; vocational counselors; educators and others as a team integrate the services which are so essential to achieve the goal. In "Rehabilitation Nursing" the author describes with clarity the important contribution the professional nurse has to make in the modern rehabilitation of the handicapped.

The book is divided into three sections. In part one an interesting historical resume is given of the practices of rehabilitation from ancient times to our present day concept of treating the patient as a whole. Part two is concerned with the fundamental technics and procedures essential to the physical restoration of the patient. Nurses will welcome the chapters dealing with the following practical aspects applicable in every-day nursing:

- (1) General bedside nursing care
- (2) Measures to prevent physical deformities
- (3) Procedures for bladder and bowel rehabilitation
- (4) Preventing and caring for decubitus ulcers
- (5) Teaching self-care activities
- (6) Teaching brace and crutch walking
- (7) Assisting with speech therapy

Part three deals with nursing practice and rehabilitation technics in the care of the amputee, the hemiplegic, the paraplegic and quadriplegic patient.

Throughout the book the author gives a warm human philosophy and practical suggestions in keeping with the current concept in caring for the total personality. This book is a valuable asset to all nurses and other allied personnel concerned in the care and treatment for all patients.

PAULA SORG, R.N., R.P.T.



## NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

*Two-thirds* of all NOPHN's members must vote "yes" on reorganization plans and must return their proxies for this purpose before the Biennial Convention if the new National League for Nursing\* is to start functioning in June, according to Emilie G. Sargent, NOPHN President.

Convention notices and proxies were mailed on March 1 to all current members of NOPHN and will continue to be mailed as dues come in. Since a deadline will have to be set—probably in May—Miss Sargent asked that anyone planning to join NOPHN do so now. All 1952 members of NOPHN will be entitled to membership for 1952 as charter members of the National League for Nursing, once it is approved.

\* The National League for Nursing is the name chosen in January by the Joint Board of Directors of the National Nursing Organizations to present for the consideration of the memberships. The National League for Nursing previously was referred to as the Nursing League of America.

## MISSING OR NON-EXISTENT?

The library finds that there is an interval from October 1939 to June 1940 in their bound volume of the Inter-Island Nurses' Bulletin. It is not known if there were actually a gap in publication or if copies have merely been lost. Those of you who have kept bulletins can perhaps answer the question. Will you check and send copies, if they are available, to the library. This particular volume is about to be rebound so this is the "psychological" moment.

## ANNOUNCEMENT

1952 Biennial Nursing Convention, Atlantic City, June 16-20. See the President of your District Association or contact Nurses' Association, Territory of Hawaii office for information regarding:

- a. Advance registration
- b. Hotel accommodations
- c. Attendance at Section meetings



now in parenteral form...

# BANTHINE®

Bromide

Brand of Methantheline Bromide

for use when oral administration is difficult or impractical  
—when more prompt action is desired

Banthine—a true anticholinergic drug with an adequate range of safety—is now made available to the medical profession in parenteral form, for use intravenously or intramuscularly in those conditions characterized by nausea and vomiting, when oral medication cannot be retained and when a prompt action is desirable.

Through its anticholinergic effects, Banthine inhibits excess vagal stimulation and controls hypermotility.

**In Peptic Ulcer** —the value of the oral form of Banthine is now well established. However, edema in the ulcer area may indicate parenteral Banthine until the healing processes have reduced the edema.

**In Pancreatitis** —it has been found that parenteral Banthine relieves pain, effects a fall in blood amylase and produces a general improvement in the patient's condition.

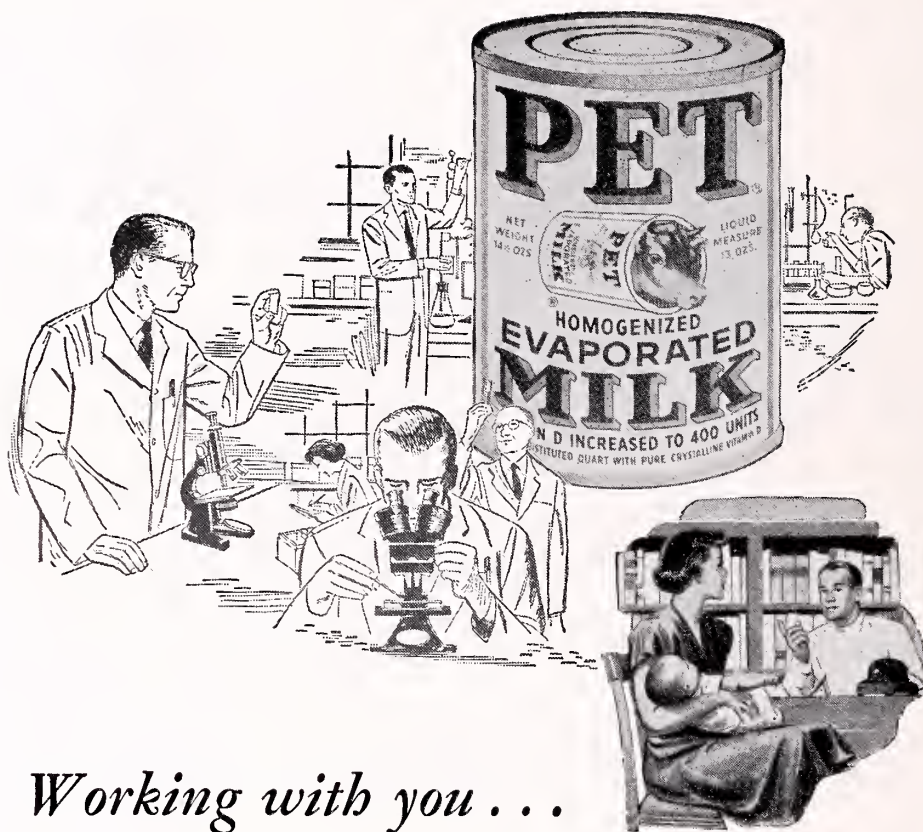
**In Visceral Spasm** —it inhibits motility of the gastrointestinal and urinary tracts.

**Parenteral BANTHINE** is supplied in serum-type ampuls containing 50 mg. of Banthine powder. Adult dosage is generally the same as with Banthine tablets.



RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**





## *Working with you . . .*

Pet Milk Company feels a responsibility that extends beyond the production of a fine food product. That's why we constantly strive to work with the medical profession . . . by doing basic research studies, supporting projects in the field of medical education and for the betterment of infant and child welfare, and by providing time-saving services to doctors, hospitals, and clinics.

These activities—above and beyond the production of evaporated milk—are made possible, of course, by Pet Milk's high standing among physicians. So many doctors recommend Pet Milk . . . the original evaporated

milk . . . for the infants in their care and for the best of reasons. Pet Milk is always surely safe, as easy to digest practically as human milk, complete in all the essential food values of milk, and the most economical form of whole milk.

Pet Milk Company is proud of its evaporated milk. We are proud, too, of our opportunity in this country to work with you. It is this kind of cooperation between medicine and industry that has contributed so much to raising our standards of infant care. It is this kind of cooperation that will continue to raise our standards even higher.

**FAVORED FORM OF MILK**



**FOR INFANT FORMULA**

**PET MILK COMPANY • 1424-C Arcade Building • St. Louis 1, Missouri**

# Terramycin

## OPHTHALMIC



Indicated in a wide range of external ocular infections involving diverse structures and tissues of the eye, Terramycin Ophthalmic preparations are effective and valuable either as the sole medication or as an adjunct to oral Terramycin therapy. It is only in the rare case that the use of Terramycin Ophthalmic Ointment or Solution is attended by sensitizing reactions.

**Supplied:** CRYSTALLINE TERRAMYCIN HYDROCHLORIDE OPTHALMIC OINTMENT, 5 mg. per Gm. ointment; tubes of  $\frac{1}{8}$  oz.

CRYSTALLINE TERRAMYCIN HYDROCHLORIDE OPTHALMIC SOLUTION, 5 cc. vials containing 25 mg. for preparation of topical solutions isotonic with lacrimal fluid and buffered to pH 8.2.

Terramycin is also available as Capsules, Elixir, Oral Drops, and Intravenous.

ANTIBIOTIC DIVISION



CHAS. PFIZER & CO., INC., Brooklyn 6, N.Y.



You practice medicine, but good  
 And that is easily understood  
  
 And as you know, it's nothing new,  
 We practice pharmacy, and too  
  
 Stand ready, day and night  
 To help your patients in their plight.



**McARTHUR & SUMMERS**  
 PRESCRIPTION • PHARMACISTS

PHONES 6-6044  
 6-8865

THIRD FLOOR - YOUNG BUILDING  
 HONOLULU, HAWAII

EMERGENCY PHONE  
 7-8411

We take great pleasure in announcing the addition of

**MISS JOY E. COCHRAN**

to our pharmaceutical staff. Miss Cochran's professional background includes experience not only in Ethical Prescription Pharmacy, but also a position as Chief Pharmacist in a two-hundred bed hospital.



**McARTHUR & SUMMERS**  
 PRESCRIPTION • PHARMACISTS

PHONES 6-6044  
 6-8865

THIRD FLOOR - YOUNG BUILDING  
 HONOLULU, HAWAII

EMERGENCY PHONE  
 7-8411

# <sup>®</sup> SULFASUXIDINE

succinylsulfathiazole

RELATIVELY

**nontoxic  
intestinal  
bacteriostat**

SULFASUXIDINE<sup>®</sup>, sulfonamide of choice for control of many enteric infections, is sparingly absorbed into the blood. Virtually nontoxic, SULFASUXIDINE remains in high concentration (95%) in the intestines to reduce bacterial flora—especially the coliform and clostridia groups. 0.5-Gm. compressed tablets (bottles of 100, 500 and 1,000); powder (1/4-lb. and 1-lb. bottles).

Sharp & Dohme, Philadelphia 1, Pa.

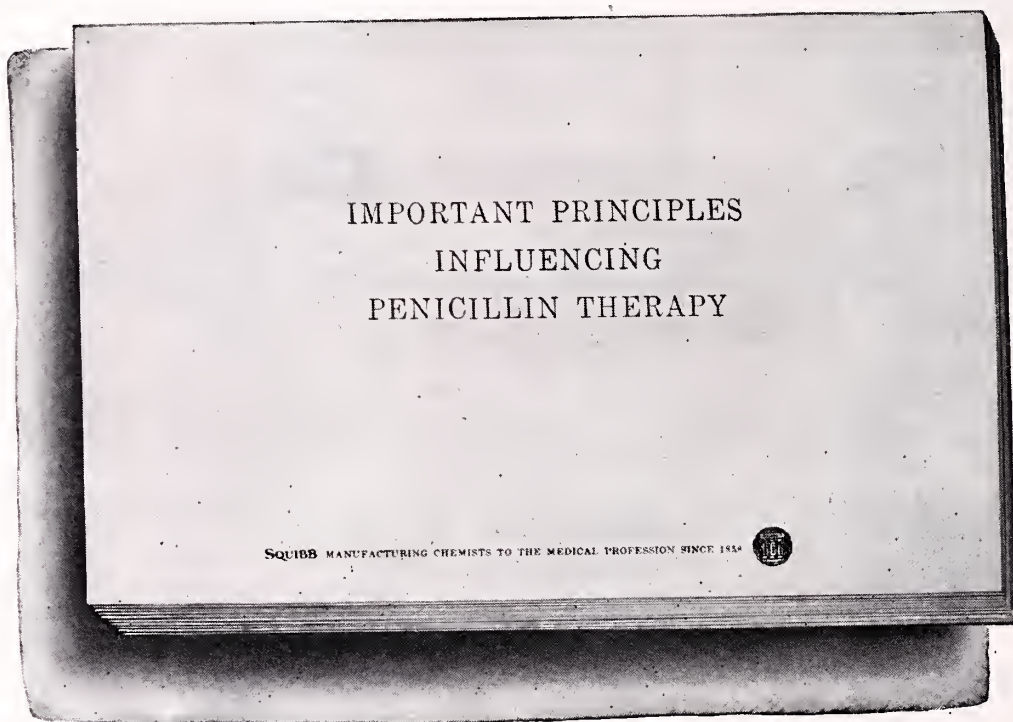


T H E O D O R E H . D A V I E S C O . , H O N O L U L U • S O L E D I S T R I B U T O R S



## Latest Information on Penicillin Therapy

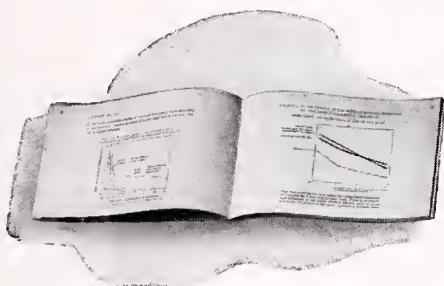
---



*Ask Your Squibb Professional Service Representative*

## ...A New Squibb Aid for the Profession

---



Squibb, a leader in penicillin research and manufacture, presents the new edition of the Squibb Penicillin Handbook, "Important Principles Influencing Penicillin Therapy." It is based on most recent clinical work and data of eminent authorities in the antibiotic field . . . new penicillin dosages . . . new recommendations for efficacy . . . oral and parenteral forms . . . combined therapy . . . drug resistance . . . therapeutic blood levels . . . reactions . . . continuous vs. discontinuous therapy . . . and many other subjects of interest to physicians.

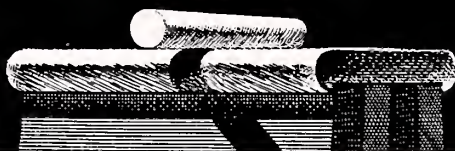
Your Squibb Professional Service Representative will provide you with "Important Principles Influencing Penicillin Therapy" or any other Squibb visual and practical aids, without cost or obligation. Or you may write direct to E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, New York.

**SQUIBB** A LEADER IN PENICILLIN RESEARCH AND MANUFACTURE





No other bulk container  
for intravenous therapy  
is as safe as  
**VACOLITER®**

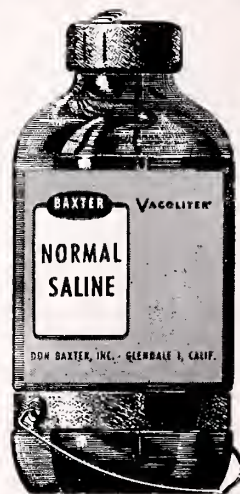


For Greater Patient Protection...

**BAXTER**

Specialists in Parenteral Therapy for Over 20 Years

**VACOLITER®**



**DON BAXTER, INC. · RESEARCH AND PRODUCTION LABORATORIES · GLENDALE 1, CALIFORNIA**

*Territorial Distributor:*

**CROCKETT SALES COMPANY**

P. O. Box 3017

• Honolulu, T. H. •

Phone 6-8992

## GROWING INDUSTRIES FOR A GROWING COMMUNITY

## POULTRY

multi-millions from chicken feed



*Hawaii today is working to build new industries to aid in expanding the islands' economy. This series of advertisements calls attention to these forward steps . . . and to their promise for Hawaii's future.*

For half a century Hawaii's farmers have been fighting disease, insects, high costs and a small market to build a big business out of breakfast omelets and dinner drumsticks. By last year their industry was returning more than \$4,000,000 annually.

In the fifty years, poultry flocks have grown from 95,000 birds to almost half a million. Egg production has increased 15 times over. Just in the past four years, the annual production of eggs has jumped nearly two million dozen and the production of chickens for food has been boosted a million pounds.

But Hawaii last year was still importing almost 25 million eggs from the mainland. It was paying mainland producers for almost four million pounds of dressed chicken, more than half of what was served on family dinner tables. It was importing both chickens and chicken feed. And Hawaii's per capita consumption of eggs and chicken was still less than half the mainland's average.

Despite the great strides, there were still great opportunities for future growth.

So in January, under the guidance of Honolulu's Chamber of Commerce, Oahu's poultry representatives met together in an industry-wide round table to talk over their common problems and share their ideas for future development. In The Hawaiian Electric Company's large auditorium more than 200 poultry raisers, breeders, feed suppliers, agricultural scientists, marketing specialists and economists listened to a six-hour discussion of industry facts and figures.

It was a practical program of business economics and there were sound signs of progress set forth in the speeches. One Oahu poultry raiser, in operation for only a few months, explained his mass-production methods for supplying 2,500 dressed fryers a week and his plans for reaching a 10,000 weekly figure by mid-year. An Oahu chicken breeder outlined his success in reducing imports by providing island farmers with island-bred baby chicks.

University of Hawaii experts and commercial feed suppliers reported on a long-range program for the development of island-produced feed. Scientists discussed the use of modern drugs and sanitation methods in reducing chicken losses. Marketing specialists introduced survey results showing marked preferences by consumers for island eggs and chickens.

Spurred by these large-scale industry developments and approaching problems on an industry-wide basis, Hawaii's poultry raisers can be expected to speed their already-rapid expansion. Hawaii can count on more island chickens and eggs for its tables, more revenue in the Territory's treasury . . . another growing industry for a growing community.



*The development of new industries requires individual initiative and community cooperation. In keeping with this progressive spirit of growth, The Hawaiian Electric Co., Ltd., is constantly planning ahead, expanding its own facilities and equipment . . . building today for tomorrow's needs.*

THE HAWAIIAN ELECTRIC CO., LTD.



BUILDING TODAY for Tomorrow's Needs



# Cortone®

Can be used Safely in the Prolonged  
Control of Rheumatoid Arthritis



BEFORE TREATMENT:

Periarticular swelling and hydrarthrosis



AFTER TREATMENT:

Diminution of pain, increased mobility, and visibly decreased effusion and swelling

## *Rehabilitation Achieved Through Conservative Dosage*

### Management in Everyday Practice

The use of simple laboratory tests (sedimentation rates, urinalyses, blood counts, blood pressure, and frequent weight recordings), individualized adjustment of dosage, and careful clinical observation will permit most patients to benefit materially . . . without fear of undesired effects.

### Effective Antirheumatic Response

Effective antirheumatic response was achieved in all 100 patients in a long-term study at the Mayo Clinic. More than 50 of these arthritics were maintained on 50 mg. or less daily. In no case was it necessary to withdraw the hormone.

Ward, L. E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.: *Proc. Staff Migs., Mayo Clinic* 26: 361, September 26, 1951.

*Literature on Request*

**Cortone®**  
ACETATE  
(CORTISONE Acetate Merck)



**MERCK & CO., INC.**  
*Manufacturing Chemists*

RAHWAY, NEW JERSEY  
In Canada: MERCK & CO. Limited—Montreal



# Dairymen's yami yogurt<sup>®</sup>

**Doctors—**

**For Patients who need nutri-  
tive but low-calorie diets—  
Patients with Obesity or di-  
gestive difficulties—**

**Recommend—Strawberry-flavored  
Yami Yogurt.**



The new added flavor and pink color are sure to make this great health-food more appealing to both children and adults.

The easy and quick digestibility, is the outstanding characteristic of Yami Yogurt, which actually aids in the digestion of other foods as well. Because of the high content of lactic acid (1 to 3%) Yami Yogurt is digested and assimilated in the proportion of approximately 95½% after three hours of digestion. By comparison, whole milk is digested in the proportion of only 44% after three hours.

Strawberry-flavored Yami Yogurt can be enjoyed daily in large quantities by patients of any age in whom milk produces dyspeptic symptoms, without causing the least discomfort. Its curd tension is zero. One ½ pound carton contains only 170 calories.

**AVAILABLE AT FOOD STORES  
AND HOME-DELIVERED.**

Dairymen's Association, Ltd., A Division of Creameries of America, Inc.



## Therapy for Vascular Headache to Reverse the Physiologic Disturbance

*Headache, a problem encountered in all kinds of medical practice, may occur in association with any of a variety of disorders, some organic, other purely functional.*

**Among the several types, functional headaches present the greatest problem because of their obscure etiology and recurrent nature.**

**Among these are:**

- Migraine (both classical and variant forms)
- Tension headache
- Psychogenic headache
- Histaminic cephalgia

**Wolff and his co-workers established that the pain of these headaches is due to disturbance of the tonus of cranial blood vessels — hence the term *vascular headaches*.**

**The craniovascular changes associated with the several phases of the typical migraine attack are:**

**Vasoconstriction** — to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)

**Vasodilatation** — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

**Vessel Edema** — if the vasodilatation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

**Therapy: 1. Reduce the frequency of attacks** — psychotherapy and regulation of living habits to avoid fatigue and nervous tension.

**2. Relieve the acute attack** — of the numerous drugs which have been tried, ergotamine and its derivative preparations have proved most effective. The newest product is oral tablets of Cafergot®, N. N. R. (ergotamine with caffeine 'Sandoz'). When dosage is adjusted to the needs of the individual, Cafergot will give good relief in 85% of cases. It enables a greater number of patients to benefit from early administration since the oral route simplifies treatment as compared to parenteral therapy.

**The dosage procedure is:**

1. Take 2 tablets at first sign of the attack.
2. If attack continues, take one additional tablet every ½ hour until attack is terminated (*max. 6 tabs. per attack*).

Many migraine patients delay taking medication until the attack is at its height. Explicit dosage instructions may be forgotten unless the patient comes to realize their importance. Therefore, to encourage adherence to correct procedure, we have prepared pads outlining detailed dosage instructions. Supplies of these INSTRUCTION SLIPS will gladly be sent upon request.

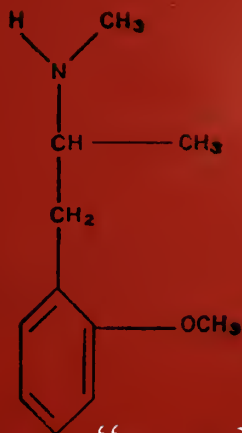
GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull 54: 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

**Sandoz Pharmaceuticals**

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, N. Y.

## INDEX TO ADVERTISERS

	PAGE
Abbott Laboratories .....	202
Ames Company, Inc. ....	196
Ayerst, McKenna & Harrison.....	198
Borden Company .....	210
Carnation Company .....	199
Dairymen's Association, Ltd. ....	257
Don Baxter, Inc. ....	254
Eli Lilly and Company.....	193, Insert
Ethicon Suture Laboratories, Inc. ....	Insert
Hawaiian Electric Company.....	255
Hinode Fortified Rice.....	240
Home Insurance Company.....	206
Hotel Import Company.....	207
Lederle Laboratories .....	208
Matson Lines .....	206
McArthur & Summers.....	250
Mead Johnson & Co. ....	260
Merck & Co., Inc. ....	256
Parke, Davis & Company.....	194, 195
Pet Milk Company.....	248
Chas. Pfizer & Co., Inc. ....	203, 249
Philip Morris & Co., Ltd., Inc. ....	224
Sandoz Pharmaceuticals .....	258
Schering Corporation .....	197
Schieffelin & Co. ....	234
Schuman Carriage Company.....	204
Searle .....	247
Sharp & Dohme.....	251
Squibb .....	252, 253
Upjohn .....	259
Wander Company .....	201
Winthrop Stearns, Inc. ....	200
Wyeth, Incorporated .....	205



the "well-trained" amine

Seven years of search and synthesis in the Upjohn laboratories culminated in the development of Orthoxine Hydrochloride—a bronchodilator and anti-spasmodic. Orthoxine's dependable action gives relief to the asthma patient with minimal vasopressor and psychomotor stimulation.

Orthoxine Hydrochloride is administered orally.

R<sub>x</sub> **Orthoxine** \*

HYDROCHLORIDE

(BRAND OF METHOXYPHENAMINE)

Bottles of 100 and 500 tablets.

Orthoxine Hydrochloride (100 mg.) Tablets contain beta-(ortho-methoxyphenyl)-isopropyl-methylamine hydrochloride—a bronchodilator and antispasmodic.

\*Trademark, Reg. U. S. Pat. Off.

product of

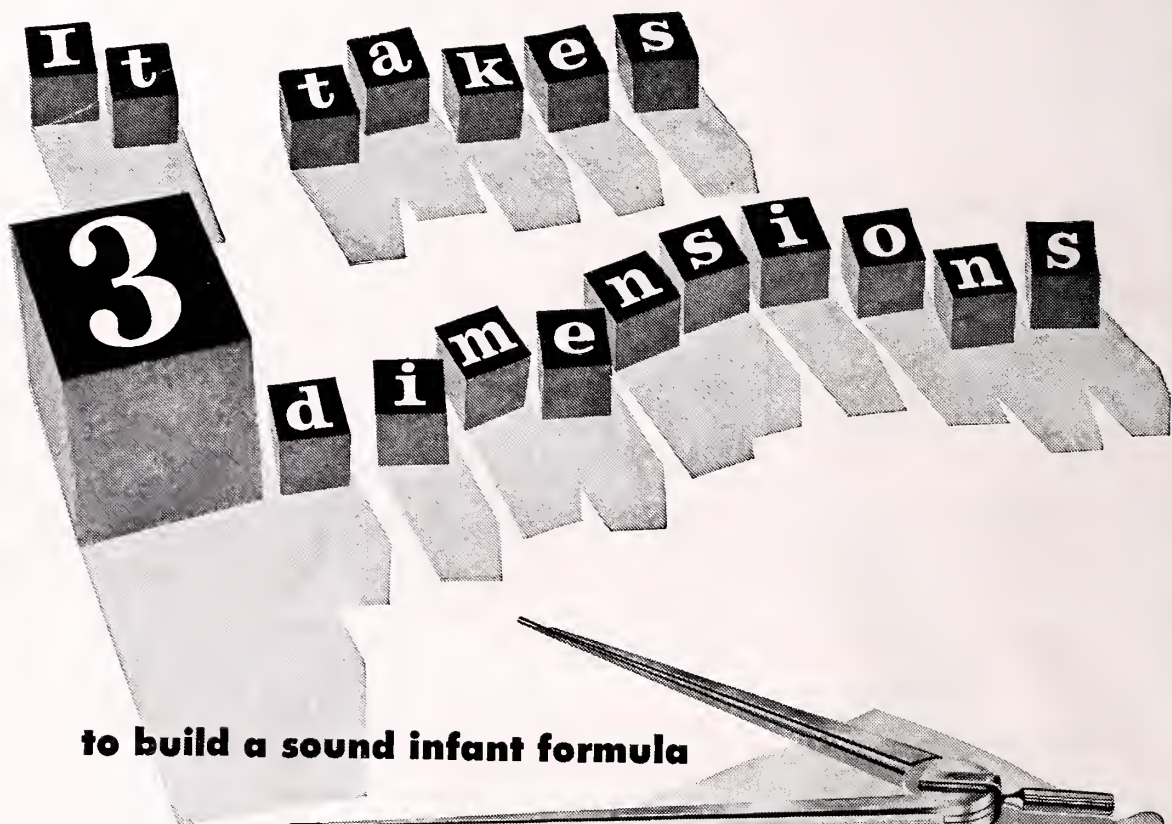
**Upjohn**

**Research**

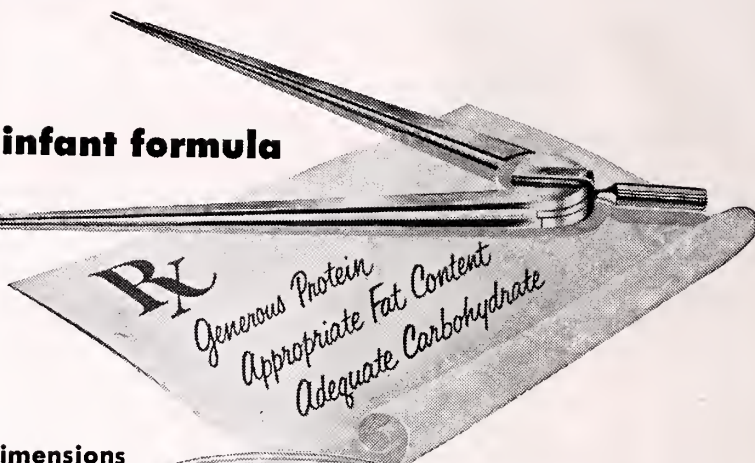
for medicine . . . produced with care . . . designed for health

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN





**to build a sound infant formula**



**LACTUM has these three dimensions**  
... for Lactum is an evaporated whole milk and Dextri-Maltose® formula.

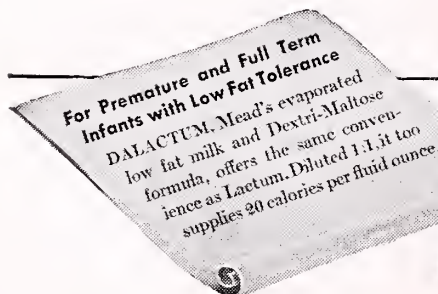
Its proportions are those of milk and Dextri-Maltose formulas used successfully in infant feeding for forty years.

And its caloric distribution (16% protein, 34% fat, 50% carbohydrate) is based on authoritative pediatric recommendations.



**and Lactum has a 4<sup>th</sup> dimension**  
... time-saving convenience

Lactum feedings are prepared simply by adding water. A 1:1 dilution provides 20 calories per fluid ounce.



**MEAD JOHNSON & CO.**  
EVANSVILLE 21, IND., U.S.A.

# AWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

MAY-JUNE, 1952

NUMBER 5

THE ACADEMY  
OF MEDICINE  
JUN 27 1952  
LIBRARY

A NEW OPERATION FOR RUPTURED INTERVERTEBRAL DISC Ralph B. Cloward.....	279
THE CONDUCT OF PREMATURE LABOR H. E. Bowles .....	286
B COMPLEX FOR VIRAL ENTERITIS Douglas H. Murray.....	289
SCLEROSING LIPOGRANULOMA Douglas B. Bell and W. Harold Civin.....	291
FEATURES .....	294
INTER-ISLAND NURSES' BULLETIN.....	311



## WHAT PRICE MEDICINE?

?

\$

*Lilly*

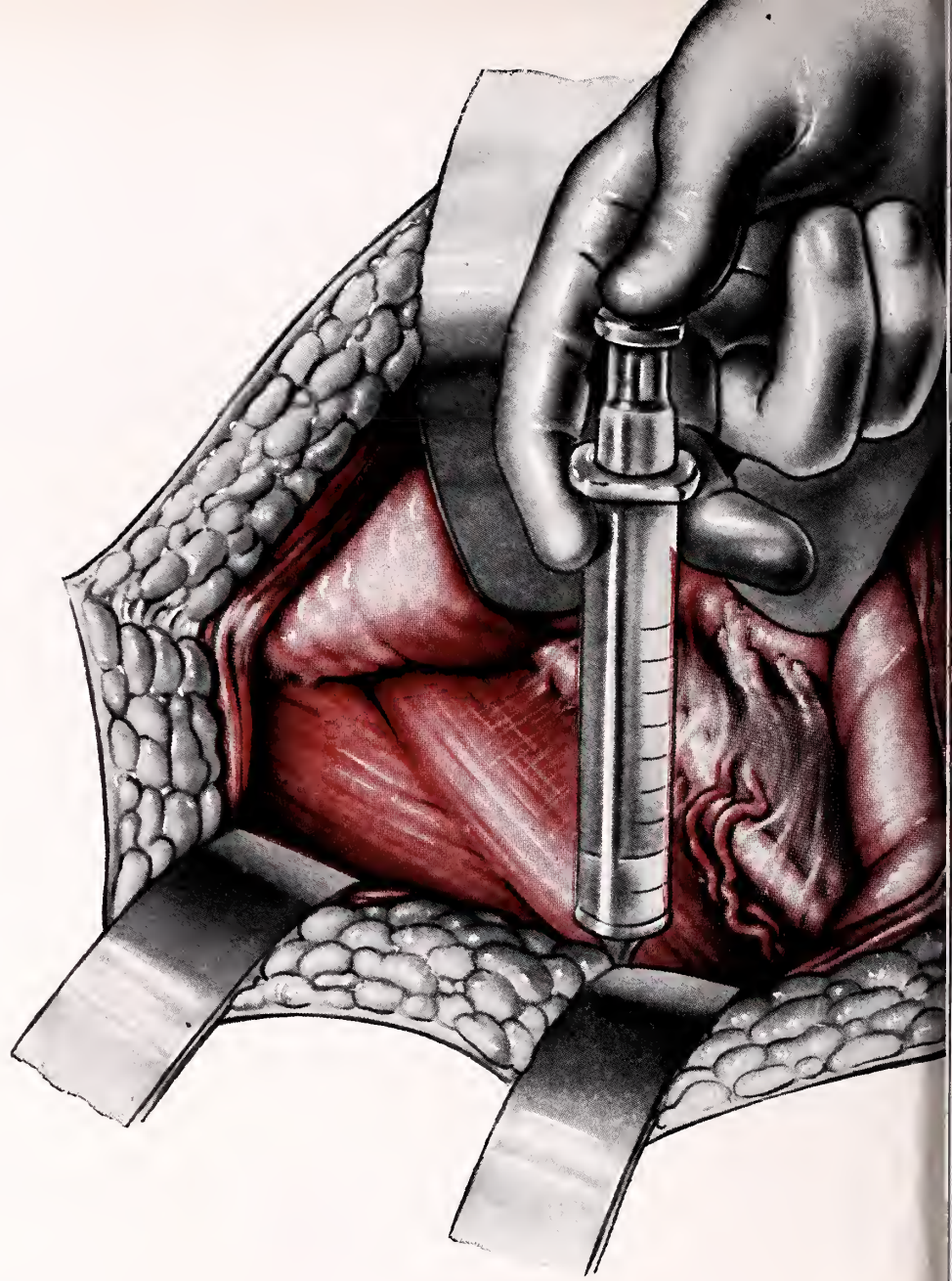


*words*

"There is hardly anything in the world that some man cannot make a little worse and sell a little cheaper, and the people who consider price only are this man's lawful prey."

—Attributed to JOHN RUSKIN (1819-1900)





# THROMBIN TOPICAL

# *Control capillary bleeding* **in seconds**

A solution containing 1,000 units of THROMBIN TOPICAL per cc. will clot an equal volume of human blood in less than one second, or ten times this volume in three seconds.

Local application of THROMBIN TOPICAL produces hemostasis almost instantaneously, for this highly purified blood derivative acts directly on the fibrinogen to form a firm, adherent, *natural* clot.

Whether you spray, flood or dust it onto affected surfaces, THROMBIN TOPICAL will help you to control capillary bleeding wherever found.

THROMBIN TOPICAL (bovine origin) is supplied in vials containing 5,000 N.I.H. units each, with a 5-cc. vial of sterile isotonic saline diluent. Also available in a package containing three vials of THROMBIN TOPICAL (1,000 N.I.H. units each) and one 6-cc. vial of diluent. Solutions of the product should never be injected.

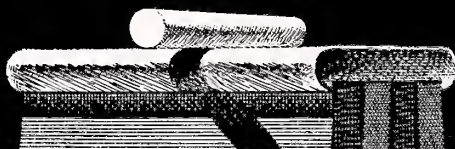


*Parke, Davis & Company*  
DETROIT, MICHIGAN



No other bulk container  
for intravenous therapy  
is as safe as

VACOLITER®

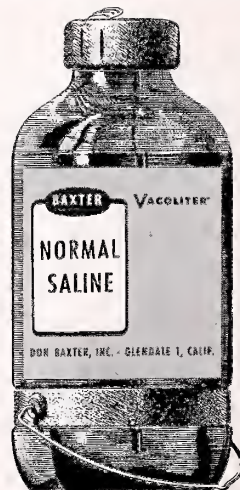


For Greater Patient Protection...

**BAXTER**

Specialists in Parenteral Therapy for Over 20 Years

**VACOLITER®**

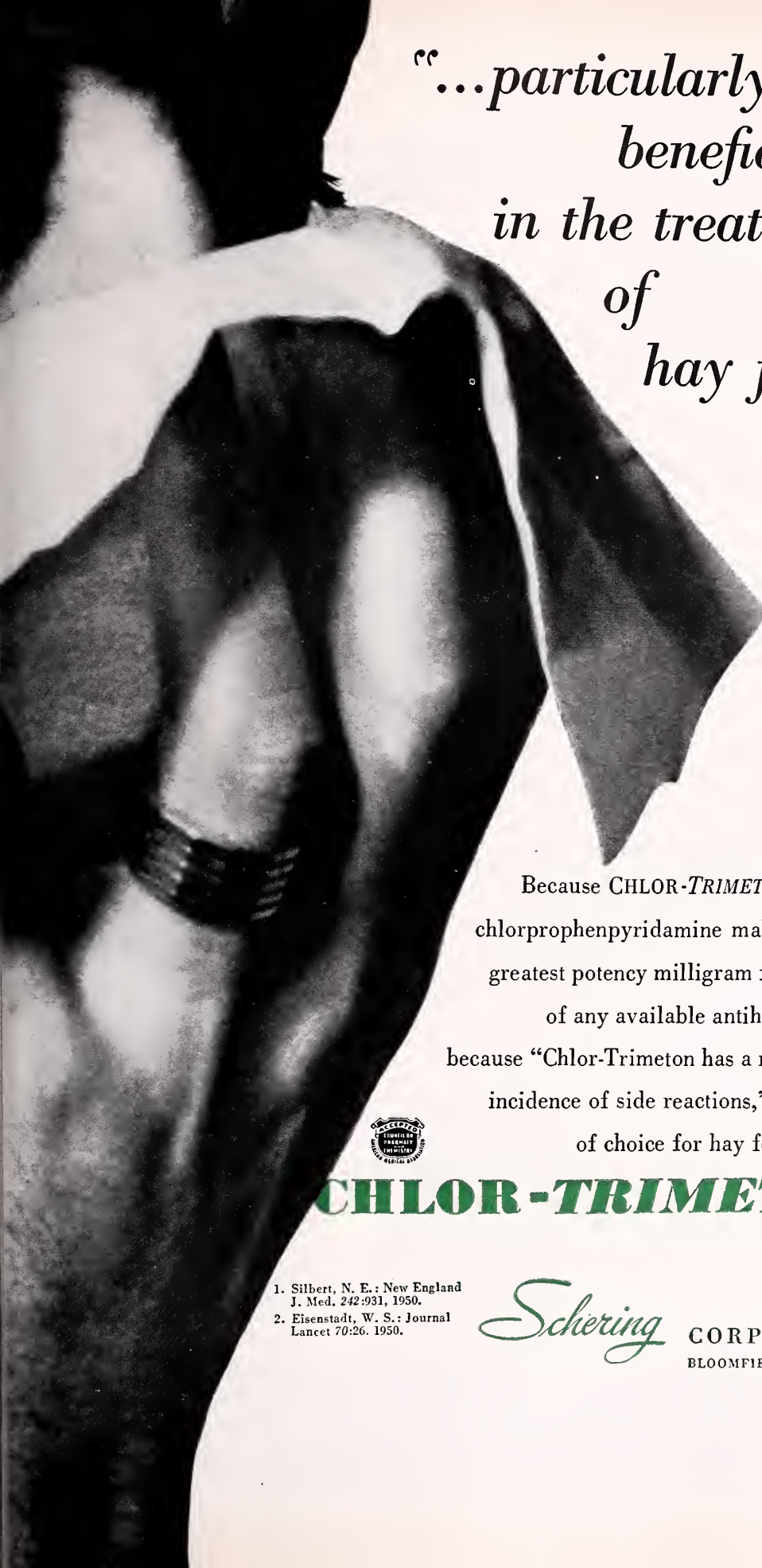


DON BAXTER, INC. • RESEARCH AND PRODUCTION LABORATORIES • GLENDALE 1, CALIFORNIA

Territorial Distributor:

**CROCKETT SALES COMPANY**

P. O. Box 3017 • Honolulu, T. H. • Phone 6-8992



*"...particularly  
beneficial  
in the treatment  
of  
hay fever."*<sup>1</sup>

Because CHLOR-TRIMETON<sup>®</sup> maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"<sup>2</sup> it is a drug of choice for hay fever patients.



**CHLOR-TRIMETON**

**maleate**

1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26, 1950.

*Schering*

CORPORATION  
BLOOMFIELD, NEW JERSEY

**CHLOR-TRIMETON**





# We've got your goat!

**A**t least we've got Meyenberg Evaporated Goat's Milk—for patients allergic to the lactalbumin of cow's milk. Meyenberg Evaporated Goat's Milk is double-rich whole milk from California's finest milk goats. Mechanical milkers draw the milk into sterilized, closed containers. Then after being tested for quality the milk is standardized, evaporated, concentrated, homogenized and hermetically sealed and sterilized under the most sanitary conditions. Meyenberg Evaporated Goat Milk may be used in all recipes calling for evaporated milk, either in the infant formula or for children and adults.



**Another Fine Product From**

**HAWAIIAN SURGICAL SUPPLY COMPANY\***

**A division of**

**HAWAIIAN GAS PRODUCTS, LTD.**

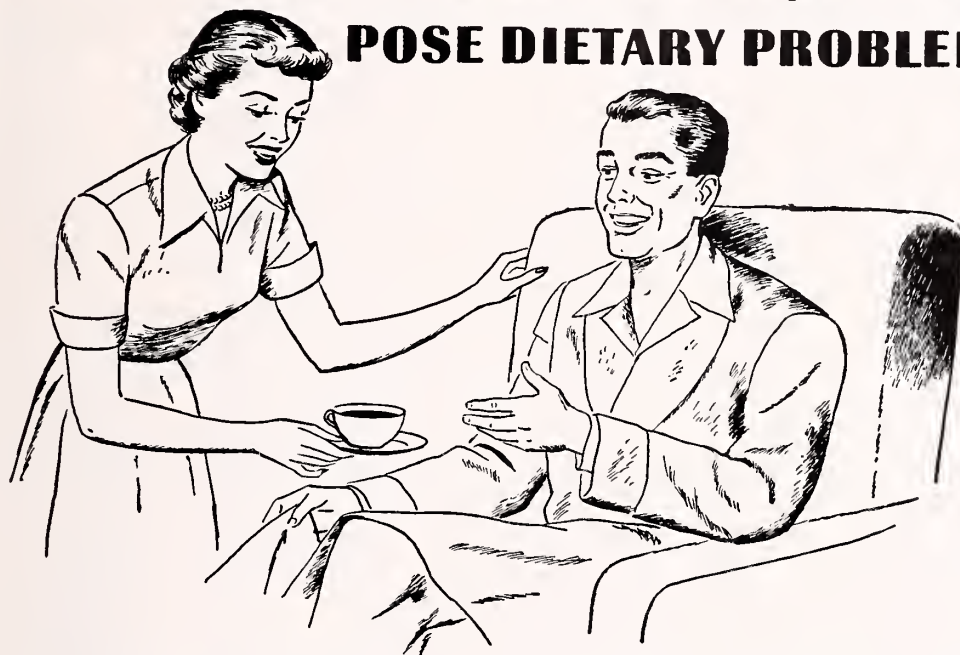
**458 Kuwili—Iwilei**

**Telephone 6-4513**

A dependable product in a recognized container—Accepted by the American Medical Association Council on foods and nutrition.

**\*Also headquarters for: Picker X-ray . . . Wyeth Biologicals . . .  
Continentalair Iceless Oxygen tents . . . E and J Resuscitators . . .  
Ohio Chemical and Surgical Equipment Co.**

# When Functional Derangements POSE DIETARY PROBLEMS



In the interest of maintaining good nutrition in the patient, many functional derangements of the gastrointestinal tract make the use of a well rounded dietary supplement, such as Ovaltine in milk, highly advantageous. Among such functional derangements more commonly encountered are nausea, anorexia, gastritis, diarrhea, dysentery, enteritis, and colitis.

In these conditions, Ovaltine in milk is particularly useful, not only because of its

easy digestibility but also because of its blandness and its high nutrient content. It offers the opportunity of providing a balanced fare of essential nutrients without mechanical irritation or excessive digestive demands. Hence it qualifies especially when customarily eaten foods are contraindicated and a nutritious bland diet is required.

The wealth of nutrients supplied by three glassfuls of Ovaltine in milk is outlined in the table below.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

## Ovaltine

Three servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk, provide:

PROTEIN . . . . .	32 Gm.	VITAMIN A . . . . .	3200 I.U.
CARBOHYDRATE . . . . .	65 Gm.	VITAMIN D . . . . .	420 I.U.
FAT . . . . .	30 Gm.	ASCORBIC ACID . . . . .	30 mg.
CALCIUM . . . . .	1.12 Gm.	NIACIN . . . . .	6.7 mg.
COPPER . . . . .	0.7 mg.	PANTOTHENIC ACID . . . . .	3.1 mg.
IODINE . . . . .	0.7 mg.	PYRIDOXINE . . . . .	0.6 mg.
IRON . . . . .	12 mg.	RIBOFLAVIN . . . . .	2.0 mg.
PHOSPHORUS . . . . .	940 mg.	THIAMINE . . . . .	1.2 mg.
CALORIES . . . . .	658		

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.





## Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: *Acta Paediatrica* 38: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNI- LATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.\* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

For symptomatic relief in these cases, **Cafergot®**, N.N.R. (ergotamine with caffeine) may be administered orally. For best results, give adequate dosage promptly.

For children within the age range 7 to 12 years—**Cafergot®** is administered, one tablet when the attack appears imminent followed by one additional tablet within 30 minutes. Not more than two **Cafergot** tablets should be administered to children within this age range.

In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. (*Total maximum dose for adults: six tablets for each attack.*)

\* Katz, J., Friedman, A.P., and Gisolfi, A.: *New York State J. Med.* 50: 2269 (Oct.) 1950.

**Sandoz Pharmaceuticals**

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, N. Y.

## What makes a Life Insurance Company GROW?

"Our primary purpose . . . is to provide the highest type of service and protection at the lowest possible cost consistent with our policyholders' best interests . . . to offer a quality product, which means sound policy contracts with broad and liberal provisions . . . through a staff of field representatives second to none in reputation and professional competence . . . to select risks carefully . . . with high standards of underwriting . . . (all of which adds up to) a high percentage of policyholders who retain their insurance through the years."

—From the President's 108th Annual Report to Policyholders.

## NEW ENGLAND MUTUAL LIFE

**Insurance Company of Boston**

1852 — 100 Years — 1952  
in Hawaii

**HOME**  **INSURANCE CO. OF HAWAII, LTD.**  
HOME INSURANCE BLDG. • 129 S. KING ST. • HONOLULU, HAWAII, U. S. A.

**General Agent**

**VIRTUALLY  
NONTOXIC**

**SULFASUXIDINE**  
SUCCINYL SULFATHIAZOLE

**BOWEL**

SULFASUXIDINE®, succinylsulfathiazole, "... materially reduces the incidence of postoperative infection in surgery of the rectum."<sup>1</sup> SULFASUXIDINE remains in high concentration in the intestinal tract, and there is no necessity of estimating the blood concentration, because succinylsulfathiazole is virtually nontoxic.<sup>2</sup> Tablets, 0.5-Gm., bottles of 100, 500 and 1,000; powder (for oral administration), 4-oz. and 1-lb. bottles.

Sharp & Dohme, Philadelphia 1, Pennsylvania.

1. J.A.M.A., 127:330, 1945. 2. J.A.M.A., 128:9, 1945.

Sharp & Dohme

**BACTERIOSTAT**



# Cortone®

Can Put Your Arthritic Patients  
BACK TO WORK



**INITIAL DOSAGE:**

25 mg. four times daily.  
Consult literature for detailed  
dosage recommendations.



**STEP-WISE REDUCTION:**

After moderate relief is  
established, reduce daily  
dosage step-wise every three  
or four days, to smallest  
suitable maintenance level.



**MAINTENANCE DOSAGE:**

25 to 50 mg. daily has been  
found adequate in more than  
50 per cent of a series of  
patients.

*Conservative dosage in rheumatoid arthritis  
provides effective relief—and often may be  
continued for long periods*

Individualized dosage, careful clinical observation, and simple, readily available laboratory procedures (sedimentation rates, urinalyses, blood counts, blood pressure, and frequent weight recordings) are adequate for the rehabilitation and management of most patients.

CORTONE is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone. This substance was first made available to the world by Merck research and production.

*Literature on request*

**Cortone®**  
ACETATE

(CORTISONE Acetate Merck)



**MERCK & CO., INC.**

*Manufacturing Chemists*

RAHWAY, NEW JERSEY

In Canada: MERCK & CO. Limited—Montreal

NOW —  
100% Safety  
OF AUTOCLAVE STERILIZATION  
For Every Office



HIGH SPEED---  
LOW COST

FASTER  
*than Boiling*  
EASIER  
*than Boiling*  
SAFER  
*than Boiling*  
CHEAPER  
*than Boiling*

Exceptionally Low Price

**\$208<sup>00</sup>**

The "777" Speed-Clave  
Wilmot CASTLE Company

(Pressure Steam Autoclave)

*Territorial Distributors*

**HOTEL IMPORT COMPANY**

Division of The VON HAMM-YOUNG COMPANY, Ltd.

Wholesale Druggists and Hospital Purveyors

Cooke and Kawaiahao Streets • Phone 6-3562

Honolulu, Hawaii, U.S.A.





**PET MILK**

**"SEALS OUT" disease germs...**

**"SEALS IN" natural food values of milk**

Physicians who recommend Pet Evaporated Milk are always sure that the babies in their care are getting a truly *safe* milk. Because Pet Milk is sterilized in its sealed container, permanently protected from any source of contamination.

At the same time there is no better, more nutritious milk for babies. Pet Milk is *complete* in the food values the best milk can be depended on to supply... and these food values are uniform wherever and whenever Pet Milk is bought.

*Yet Pet Milk, the original evaporated milk, costs less than any other form of milk—far less than special infant feeding preparations!*

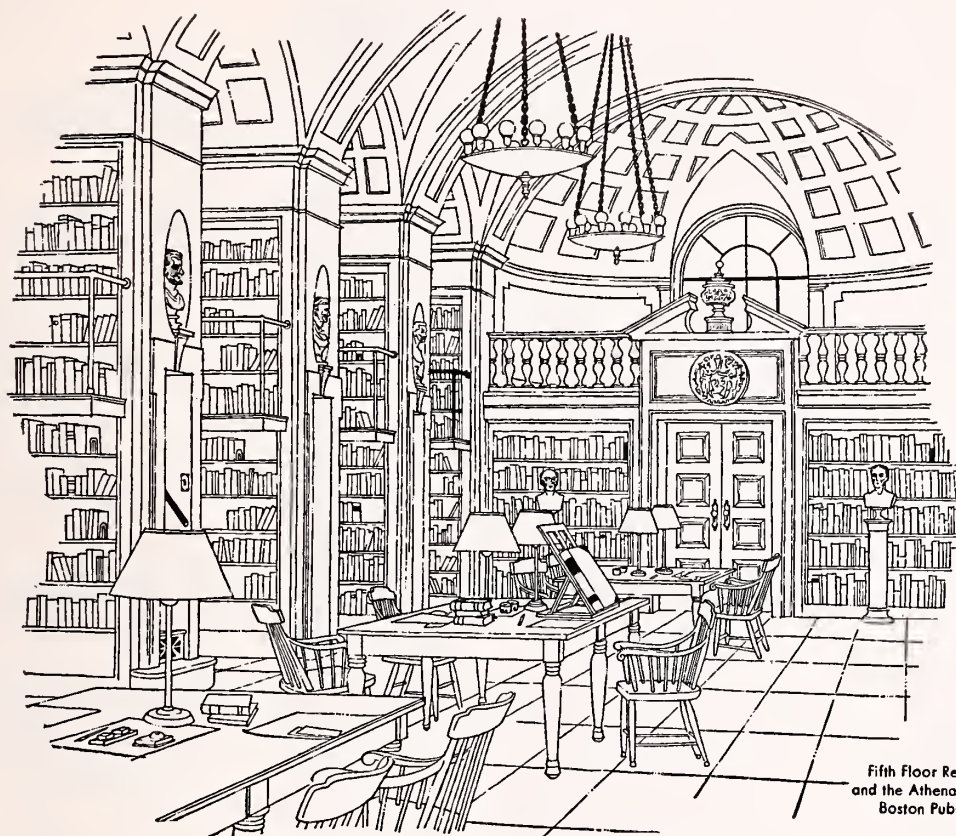
Try PET Evaporated Milk for your young patients. See how this good milk helps them grow sturdy and strong.



FAVORED FORM OF MILK FOR

INFANT FORMULA

PET MILK COMPANY, 1424-E Arcade Building, St. Louis 1, Missouri



Fifth Floor Reading Room  
and the Athenaeum Entrance,  
Boston Public Library.

*From among all antibiotics,  
Obstetricians and Gynecologists often choose*

# AUREOMYCIN

*Hydrochloride Crystalline*

**Because**

Aureomycin diffuses so rapidly that it becomes available immediately to all the tissues in and about the pelvis.

Aureomycin readily passes into the blood stream, and through the placenta into the fetal circulation.

Aureomycin may be given by the oral, or in an emergency by the intravenous, route.

Aureomycin has been reported clinically effective when used systemically against susceptible organisms in many gynecologic and obstetrical infections, including:

Parenteral and Post-partum Infectious Complications • Mastitis • Thrombophlebitis • Pyelitis of Pregnancy • Staphylococcal Infection in the Newborn

*Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.*

*Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100.  
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.*

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N. Y.





Doctor,  
be your own  
judge...  
try this  
simple test

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come *directly* through your nose.
2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between

PHILIP MORRIS and any other leading brand.

**PHILIP MORRIS**

Philip Morris & Co. Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

# ***RICHER* THAN NEED BE!**



Dairymen's Grade AA Fresh Milk (both Cream Top and Homogenized) exceeds Territorial requirements for butterfat content and milk solids. And Dairyman's Golden Guernsey milk is one-third richer still!

## **Yami Yogurt—**

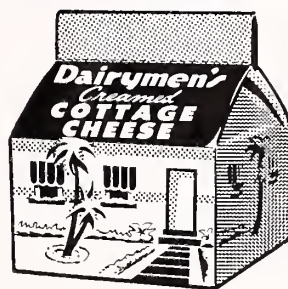
(plain and strawberry-flavored)

The only yogurt made from the original Rosell Dairy Institute Culture, which is flown in fresh every week for final preparation at Dairyman's.



## **Creamed Cottage Cheese—**

Dairymen's — the only locally prepared cottage cheese that is sanitarily machine packed (not hand-dipped from vat to container). Creamed to provide extra butterfat.



..... **Dairymen's**

**Country-Fresh Farm-Rich Milk  
And Wholesome Dairy Products**

Dairymen's Association, Ltd.

*A Division of Creameries of America, Inc.*



# DIAGNOSIS



SHOWS CAR TO BE.....

Obviously beautiful . . . of the finest the automotive industry has developed. Bears the reputation as the "standard of the World." Performs brilliantly, as its 190 horsepower engine is the greatest of all American makes.

Guaranteed—for long life and lasting popularity.

*R* . . . for the medical profession!

## Cadillac

*POWER STEERING, Cadillac's new 1952 motoring aid that takes the effort out of driving and makes parking easy, is available on all Mainland delivery Cadillacs in New York, San Francisco and Detroit, after May 1st.*

Open Thursdays till 9 p.m.

• Saturdays till 4 p.m.



**SCHUMAN CARRIAGE COMPANY**

Established 1893 • BERETANIA AT RICHARDS STREET, HONOLULU

# HAWAII MEDICAL JOURNAL

and

## INTER-ISLAND NURSES' BULLETIN

Volume 11  
Number 5

MAY-JUNE, 1952

\$2.00 per year  
35c per copy

Published Bi-Monthly by  
THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

### THE HAWAII TERRITORIAL MEDICAL ASSOCIATION

1952-1953

#### OFFICERS

R. J. McARTHUR, Wailuku, Maui.....	President
E. K. CHUNG-HOON, Honolulu.....	President-Elect
S. KASAMOTO, Hilo.....	Vice-President from Hawaii County
WILLIAM M. WALSH, Honolulu.....	Vice-President from Honolulu County
MARVIN BRENNECKE, Waimea.....	Vice-President from Kauai County
J. ALFRED BURDEN, Paia.....	Vice-President from Maui County
SAMUEL L. YEE, Honolulu.....	Secretary
THOMAS H. RICHERT, Honolulu.....	Treasurer

#### OFFICERS — COUNTY SOCIETIES

HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....S. Kasamoto, Hilo	Wm. M. Walsh	Marvin Brennecke, Waimea	J. Alfred Burden, Paia
<i>Vice-President</i> .....C. Hayashi, Kealahou	Wm. S. Ito	C. H. Ishii, Lihue	Harold Kushi, Kahului
<i>Secretary</i> .....R. Yamanoha, Hilo	C. M. Burgess	Peter Kim, Kealia	Edmund Tompkins, Waiahoa
<i>Treasurer</i> .....Kay Ota, Hilo	R. C. Durant	Peter Kim, Kealia	Edmund Tompkins, Waiahoa

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1952, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.






**I**N artificial feeding, DRYCO stands out as the ideal infant food in every significant respect. We invite you to compare the specific advantages of DRYCO with any other infant food, as a supplement or substitute of breast milk.

DRYCO is pure, nutritious cow's milk, not merely modified to "imitate" the analysis of human milk, but correctly adjusted to compensate for the major biological differences between cow's milk and human milk. Dryco is a superior substitute for breast milk.

The following vital factors account for the superiority of DRYCO as an infant food:

 • **SUFFICIENTLY HIGH PROTEIN LEVEL.** Provides the required amount of amino acids essential to the growth of infants.



• **REDUCED FAT CONTENT.** Adequate for nutrition but helps avoid digestive upsets often associated with high fat feedings.



• **FLEXIBILITY.** Moderate carbohydrate content keeps this factor under individual control of the prescribing physician.



• **VITAMINS AND MINERALS.** Adequate natural amounts of vitamins B<sub>1</sub> and B<sub>2</sub>(G). Fortified with vitamins A and D. Generous supply of calcium and phosphorus.

#### COMPARE DRYCO WITH ANY OTHER INFANT FOOD

DRYCO stands out as an ideal food for infants . . . nutritious, practical and economical. For over 30 years DRYCO has enjoyed an impressive clinical record in infant feeding.

*Compare Dryco for quality! Prescribe Dryco with confidence!*

# DRYCO

THE BORDEN COMPANY • 350 MADISON AVENUE

New York 17, N. Y., U. S. A.

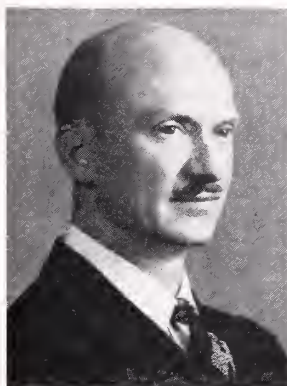
# Recent Improvements in the Surgical Treatment of Low Back Pain Due to Ruptured Lumbar Intervertebral Discs

RALPH B. CLOWARD, M.D.

HONOLULU

THE MEDICAL literature having to do with the surgical treatment of the ruptured lumbar intervertebral disc is filled with controversy as to the type of therapy patients with this condition should receive. This controversy is obviously due to the fact that numerous patients have not been relieved of their symptoms by surgical treatment. Many surgeons<sup>1</sup> are advising spinal fusion operations for all ruptured disc patients; as many neurosurgeons<sup>2</sup> report just as good over-all results by simple removal of the herniated fragment of the ruptured disc. The high percentage of patients not cured by either of these procedures has resulted in an even more conservative attitude by some. This was recommended in a recent editorial in the J.A.M.A.,<sup>3</sup> in which the benefits by surgical treatment were questioned. There are few problems in surgery today in which so much diversity of opinion exists as to the type of treatment necessary to completely cure a patient with intractable low back pain and sciatica. Operative methods used by most surgeons throughout the world today have shown little change in the past ten years. The medical profession, therefore, is no nearer to the solution of the disc problem now than it was then.

Over a five year period, from 1938 to 1943, the writer tried various surgical procedures in an effort to cure the patient with a ruptured disc. A high percentage of failures was observed among this early group of patients (over 30 percent have subsequently required a second operation). This experience led the writer to the development of a new operative procedure, the vertebral body fusion.<sup>4</sup> The normal intervertebral disc functions to hold the adjacent vertebral bodies apart. When



DR. CLOWARD

the disc is ruptured, the weight of the body collapses it (Fig. 7a), the intervertebral support is lost, and a weak, mobile and painful vertebral joint may result. Protrusion or herniation of fragments of torn disc into the spinal canal may occur later giving nerve root pressure and sciatic pain. This symptom, however, is

a complication of the ruptured disc and not the primary pathology.

The new operative approach to the treatment of this traumatic condition was directed toward, first, an attempt to preserve or re-establish the normal intervertebral space, and second, to stabilize the weak joint by fusion of the adjacent vertebral bodies. To accomplish this, therefore, an effort was made to remove the intervertebral disc, including the cartilaginous plate and cortical surface of the vertebral bodies, and replace it with large plugs of bone. The bone plugs are full thickness grafts obtained from the crest of the ilium. This operative procedure has been performed by the writer on almost every ruptured intervertebral disc case operated upon since 1944. To date, a total of over 250 patients have been subjected to this procedure. In this group, the high percentage of permanent cures with no residual disability compared to those treated before 1944 has convinced the writer that this operation is the treatment of choice for ruptured lumbar intervertebral disc.

Obviously as more cases have been done, the operative technic has changed and improved upon, resulting in marked improvement in the end results. It is the purpose of this communication to numerate the advancements made in this operation in the past year or so. Many of them are extremely important, being beneficial to the patient from the physical as well as the economic standpoint, and helpful to the surgeon performing the operation.

Received for publication April 2, 1952.

<sup>1</sup> Barr, J. S.: Ruptured Intervertebral Disc and Sciatic Pain, *J. Bone & Joint Surg.* 29:429 (Apr.) 1947. Smith, A. DeF.; Deery, E. M.; and Hagman, G. L.: Herniation of the Nucleus Pulposus. A Study of One Hundred Cases Treated by Operation, *J. Bone & Joint Surg.* 26:821 (Oct.) 1944.

<sup>2</sup> Lenhard, R. E.: End Results Study of the Intervertebral Disc, *J. Bone & Joint Surg.* 29:425 (Apr.) 1947. Spurling, G., and Grantham, E. G.: Ruptured Intervertebral Disc in the Lumbar Region, *Am. J. Surg.* 75:140 (Jan.) 1948. O'Connell, J. E. A.: Indications for and End Results of the Excision of Lumbar Intervertebral Protrusion. A review of 500 cases, *Ann. Roy. Coll. Surgeons London, England* 6: 403 (June) 1950.

<sup>3</sup> Editorial, Surgical Treatment of the Lumbar Disk Lesion, *J.A.M.A.* 146:732 (June 23) 1951.

<sup>4</sup> Cloward, R. B.: New Treatment for Ruptured Intervertebral Disc. Read at Annual Meeting of Hawaii Territorial Medical Association. May 3, 1945 (unpublished).



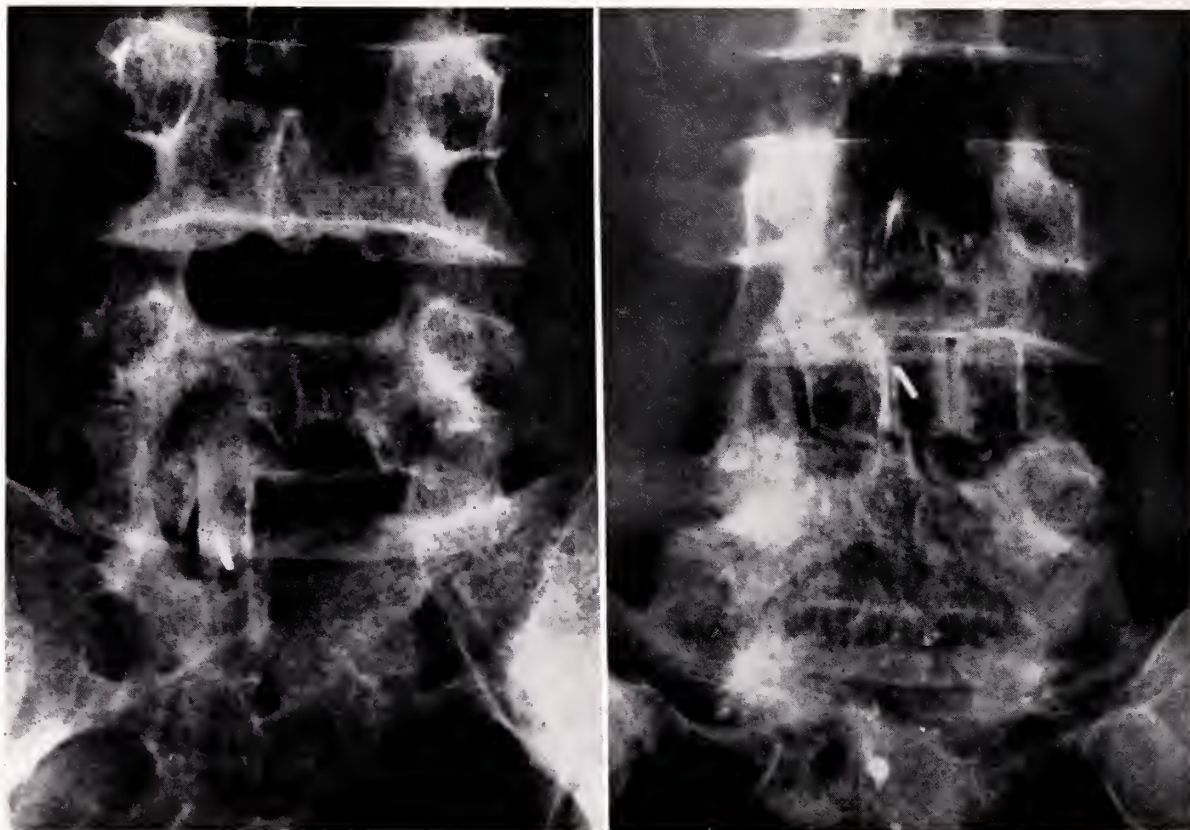


FIG. 1.—a. Antero-posterior x-ray of vertebral body fusion (1944). One bone wedge used to replace part of lumbo-sacral disc removed at site of herniation. b. Three bone "plugs" replacing intervertebral disc L4-5 (1949).

### Operative Technic

In the early days of the operation for vertebral body fusion, the bone grafting was performed on one side of the spinal canal only. The disc was removed unilaterally on the side of the patient's sciatica, replaced with a single bone graft and the remainder of the intervertebral disc was left intact<sup>5</sup> (Fig. 1a). Later an attempt was made to remove more of the intervertebral disc and to replace it with larger quantities of bone, to increase the stability of the intervertebral joint. At the present time, a subtotal removal of the intervertebral disc is done from both sides of the dural sac, far out laterally beneath the vertebral pedicle. Three, four, sometimes more, full-thickness iliac grafts are driven forcibly into the interspace (Fig. 1b). The more extensive grafting, using larger quantities of bone, assures a complete mechanical fixation of the intervertebral joint before the patient is off the operating table. This improvement in the operation has made it possible for the patient to be out of bed, bearing weight on

the joint within a week after the operation. He is able to leave the hospital on or about his tenth post-operative day.

With this type of spine fixation, the use of a back brace has been found unnecessary. Prior to 1951 all patients were fitted with a Taylor back brace costing from \$40.00 to \$60.00 and were requested to wear this brace for about three months or until the x-rays demonstrated bony union of the vertebral bodies. Since the use of the back brace was discontinued no difference in the rate of fusion has been observed. We have seen, however, considerable improvement in the comfort of the patient. Patients not wearing a back brace are permitted to use their back muscles from the beginning. Shortening and fibrosis of the muscles may result from wearing a back brace too long. It is possible this may be partly responsible for the stiffness and back pain occasionally encountered after the ordinary spinal fusion operation. Patients not wearing a brace have been able as early as thirty days or less after operation to bend freely in all directions, some being able to bend forward and touch the floor with their fingertips without pain.

<sup>5</sup> Cloward, R. B.: Treatment of Ruptured Intervertebral Disc by Intervertebral Fusion; Report of 100 Cases. Read at Annual Meeting of Harvey Cushing Society, Hot Springs, Va., Nov. 1947 (unpublished).

Instruments

With any new operative procedure, one usually finds the available surgical instruments inadequate. Development of new instruments to facilitate any new operation is often mandatory. In the past year the writer has devised several new instruments for this procedure which have made the operation easier from a technical standpoint, so that the operative time has been considerably reduced. Most important, however, is the safety factor in eliminating post-operative complications. From the patient's standpoint, the new instruments have lessened post-operative pain both at the operative site and in the lower extremities, and have removed the danger of injury to the roots of the cauda equina.

Surgeons have objected to the writer's operation of vertebral body fusion for several reasons.<sup>6</sup> The chief reasons have been, first: the danger of injuring the nerve roots or the cauda equina, and second: the inability to obtain an adequate exposure of the operative field to permit removal of the intervertebral disc and grafting of the vertebral bodies. These two objections have been overcome by the development of two instruments.

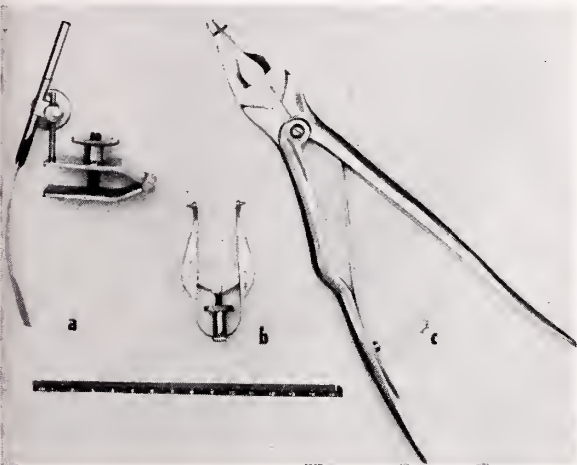


FIG. 2.—New instruments used for vertebral body fusion. a. Self-retaining spinal dura retractor. b. Vertebra spreader, and c. Handle.

The first instrument, a Vertebrae Spreader<sup>7</sup> (Fig. 2b), is a self-retaining retractor which separates the laminae and opens up the intervertebral space. This small self-retaining retractor is placed at the base of the spinous processes, and with a large detachable handle, is forced apart and held there by turning a small screw. With this instru-

ment, the intervertebral space can be almost doubled in width, giving a wider exposure through which the disc can be removed and replaced with the bone plugs. A wider opening permits the insertion of larger bone grafts, locking the vertebra more solidly together (apart). (Fig. 7b). This has improved the operation and the end results remarkably.

The second instrument is the Self-Retaining Dura Retractor<sup>8</sup> (Fig. 2a), an instrument devised to hold back the nerve root and the dura mater mechanically while the surgeon has both hands free to operate anterior to the spinal canal. This instrument, which attaches to any laminectomy retractor, consists of a long spatula which is secured beneath the nerve root, retracted to the midline and held there by turning a large screw. An excellent visualization of the anterior wall of the spinal canal is thus obtained and, as stated above, the surgeon has both hands free to complete the operation. The instrument, which is used like a shoe-horn, has removed the hazard of injury to the nerve root or cauda equina when the bone plugs are driven into the intervertebral space. The pulling and hauling on the nerve root by a manual retractor has resulted in injury to the nerve roots, causing disagreeable post-operative complications, such as urinary retention, numbness of the foot and leg or even foot-drop (motor weakness). None of these complications have occurred since this instrument has been in use.

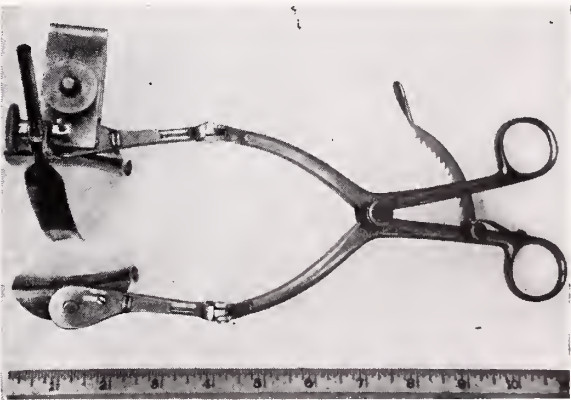


FIG. 3.—Modified Hoen self-retaining laminectomy retractor with special blades and dura retractor attached.

Other instruments devised for this procedure consist of specially designed blades for the self-retaining laminectomy retractor (Fig. 3). These hold the wound open widely, giving adequate exposure of the vertebra without chewing up the lumbar muscles as so many claw type retractors

<sup>6</sup> Bailey, P. B.: The Year Book of Neurology, Psychiatry & Neurosurgery, Chicago, Year Book Publishers, 1950, p. 530.

<sup>7</sup> Cloward, R. B.: Lumbar Intervertebral Disc Surgery with Description of a New Instrument, "The Vertebrae Spreader", Surgery (in press).

<sup>8</sup> Cloward, R. B.: A Self Retaining Dura Retractor, J. Neurosurg. 9:230 (Mar.) 1952.



do.<sup>9</sup> The use of smooth blades has reduced immediate post-operative pain in the wound and hastens healing. Long handled instruments such as a large pituitary rongeur for removing the disc material, curettes, narrow chisels, a large punch, etc. are other important instruments which facilitate the operation.

### Bone Bank

For the first three years this operation was performed, the average operative time was four and one-half hours. It was necessary to make a second incision over the crest of the ilium and remove the bone grafts before the laminectomy procedure could be carried out. Post-operatively, patients often complained more of pain and discomfort over the ilium (the donor site) than they did from the midline operation. Injury to the cluneal nerves and stripping of the gluteal muscles from the iliac crest resulted in pain and disability which required longer hospitalization. This hip pain often continued for months or years.



FIG. 4.—Iliac bone cut into "plugs" and preserved in plasma ready for Bone Bank.

In 1946, in an effort to prevent these disagreeable symptoms and to shorten the length of the operation, the writer conceived the idea of using banked bone for the bone grafts. Although experimental work had been done in preservation and use of hemogenous bone in surgery<sup>10</sup> there were very few bone banks throughout the country at that time and very few articles existed in the medical literature on the use of preserved bone in surgery. With the aid of Mrs. Hazel Bond of the Honolulu Blood Bank, a bone bank was started. Experiments were carried out with various methods of preservation and sterilization of cadaver bone. By the latter part of 1946, we began using banked bone for this operation (Fig. 4). Because of the difficulty of obtaining autopsy material for our bone bank, however, it was not used extensively until 1950. From 1947 through 1950, 30

patients were operated upon using banked bone. In the past fifteen months, banked bone has been used on almost every patient. A total of 38 cases were operated upon in 1951 and only in 3 cases was the patient's own bone used. A total of 87 vertebral body fusions using banked bone have been performed by the writer up to the present time.

The advantages of a bone bank for this operation are obvious. The second operation is unnecessary; the patient has one and not two wounds to heal. The operative time is cut almost in half and a larger quantity of bone being available, a much more extensive grafting procedure can be carried out. Complications such as infection of the bone grafts have not been seen in any greater numbers than were encountered when the patient's own bone was used. In the 87 cases in which banked bone was used, we have had 8 wound infections. In 3 of these the bone became infected. Two patients cleared up with antibiotic therapy and went on to a solid fusion. The other patient, a nurse, lost the bone grafts. Two months later she was fused again with banked bone and healed without incident. The other 5 patients had superficial "stitch" infections. The infection rate using banked bone is lower than that encountered in the early days of body fusion operation when the patient's own bone was used, probably because when banked bone is used, the wound is open for a much shorter time. The rate at which the fusion takes place as determined by x-ray is the same, if not faster, with banked bone. This factor may be influenced by the use of large quantities of bone and early ambulation which, we believe, stimulates more rapid bone growth (Fig. 7b).

### Diagnostic Procedure

One of the most important additions to our armamentarium in the diagnosis and, therefore, treatment of the ruptured lumbar intervertebral disc is the new diagnostic procedure presented to the medical profession about one year ago, known as the Discogram. In the past, the diagnosis of a ruptured intervertebral disc depended, first, on the patient's history; second, his physical and neurological findings; and third, on x-ray findings of either bony changes in the spine or by use of contrast medium within the spinal canal. The confirmation of a clinical diagnosis by myelography has discouraged many surgeons and roentgenologists. Patients whose myelogram appeared perfectly normal would be found to have a ruptured disc at surgery, and other patients with what appeared to be a positive myelogram would have a negative surgical exploration.

<sup>9</sup> Mack, E. W.: Electromyelographic Observation on Post-operative Disc Patients, *J. Neurosurg.* 8:469 (Sept.) 1951.

<sup>10</sup> Carrel, Alexis: The Preservation of Tissue and Its Application in Surgery, *J.A.M.A.* 59:523 (Aug. 17) 1912. Inclan, A.: The Use of Preserved Bone Graft in Orthopedic Surgery, *J. Bone & Joint Surg.* 24:81 (Jan.) 1942.

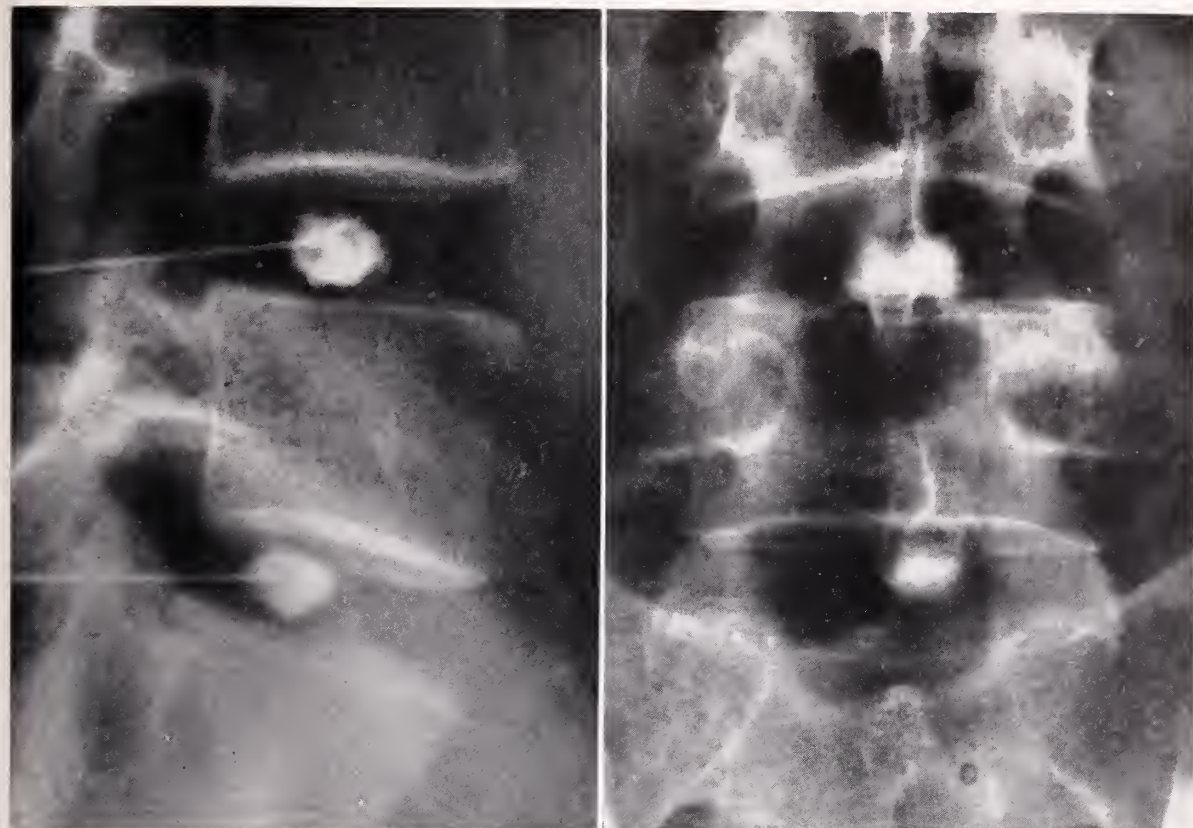


FIG. 5.—Normal discogram. Only the nucleus pulposus is made opaque by Diodrast.

Discography was introduced by Dr. Kirk Lindbloom, a radiologist, in Stockholm, Sweden.<sup>11</sup> He conceived the idea of visualizing the intervertebral disc itself by a direct puncture of a disc and injection of a contrast material within the disc substance. Injecting a 35 percent solution of Diodrast through a long, very fine spinal puncture needle, the nucleus pulposus is beautifully demonstrated on the x-ray (Fig. 5). In a normal intervertebral disc, only the nucleus pulposus is stained by the dye. If the fibers of the annulus fibrosus are ruptured and a collapse of the nucleus results in a disorganization and degeneration of the disc, the entire intervertebral space will be filled with diodrast. This is irrefutable evidence of a ruptured disc. This procedure makes possible a roentgenologic diagnosis of the cause of low back pain before the patient develops the tell-tale sciatica. Pain in the lower extremity does not appear until a portion of the torn disc becomes herniated into the spinal canal. Many of these patients with disc injuries go for years with disabling low back pain before the sciatica occurs. Until the present time, we have not had a diagnostic procedure which would give

the positive objective pathologic etiology of back pain due to a ruptured disc. With the aid of this procedure, we are able to diagnose cases of ruptured disc before they develop a sciatica. The disc can be removed, the vertebral bodies fused, the backache cured and the patient returned to work without ever having experienced the sciatic pain. The symptom of leg pain has always been the prerequisite upon which the diagnosis of ruptured disc depended, and, therefore, the recommendation for surgical treatment.

The writer began doing the discogram procedure in January, 1951, and since that time 37 discograms have been performed. Of these 34 pathological discs have been demonstrated. A double lesion was found in six patients. The frequency of multiple ruptured discs has been pointed out by some neurosurgeons, but most of us have been reluctant to cut into a disc if it showed no evidence of herniation into the spinal canal as demonstrated by myelography or on direct inspection at operation. The discogram has changed this. We have seen anterior and lateral herniations of the torn disc<sup>12</sup> (Fig. 6) as often as posterior

<sup>11</sup> Lindbloom, K.: Technique and Results in Myelography and Disc Puncture, *Acta Radiol.* 34:321, 1950. Lindbloom, K.: Contrast Medium Injection, *Acta Orthop. Scandinav.* 20:315, 1951.

<sup>12</sup> Cloward, R. B.: Anterior Herniation of a Ruptured Lumbar Intervertebral Disc with Comments on the Diagnostic Value of the Discogram, *Arch. Surg.* 64:457 (Apr.) 1952.





FIG. 6.—Abnormal discogram showing anterior rupture and herniation of disc rather than posterior (arrow). This patient had intractable low back pain without sciatica.

protrusions. Frequent collapse and complete disorganization of the disc is demonstrated when none was suspected. The "negative exploration" of a suspected ruptured disc is now a thing of the past. With the discogram we know before surgery whether the disc is ruptured or not. We have been so satisfied with the reliability of this procedure that we prefer it to the myelogram in the diagnostic workup of most disc cases.

#### Statistics and Results

The advantages to the patient of these operative improvements are considerable. Two groups of patients were taken for comparison, those operated upon in 1948 (43 cases) and those in 1951 (41 cases). From an economic standpoint the cost of the operation to the patient or his insurance company is important. The high cost of medical care today, particularly hospitalization, makes a long drawn-out surgical procedure almost prohibitive to the average family. The entire cost of hospitali-

TABLE 1.—Comparison of Cases Operated Upon for Ruptured Intervertebral Discs in 1948 and in 1951.

	1948	1951
1. Number of Patients.....	43	41
2. History		
Back pain duration.....	4.1 years	6 years
Leg pain duration.....	2 years	3.2 years
3. Symptoms		
Back pain only.....	2—4%	4—9.9%
Pain in back and one leg.....	33—76%	30—73.1%
Pain in back and both legs.....	9—20%	7—17%
4. Location of Lesion		
L3-4.....	4—9.3%	1—2.5%
L4-5.....	25—58.2%	29—65.8%
L5-S1.....	14—32.5%	13—31.7%
Two discs.....	0	2—1%
5. Sex		
Male.....	33—76%	33—80.5%
Female.....	10—24%	8—19.5%
6. Age		
Under 30 years.....	9—21%	17—42%
30 to 40 years.....	19—44%	12—29%
Over 40 years.....	15—35%	12—29%
7. Length of Operation (av.).....	4 hr. 12 min.	2 hr. 34 min.
8. Bone Grafts		
Patient's own bone.....	35	3
Bone Bank.....	8	38
9. Infections.....	4	0
10. Back Brace.....	43	2
11. Days in Hospital (av.).....	22.4 days	13.8 days
12. Hospital Cost (av.).....	\$470.45	\$278.60

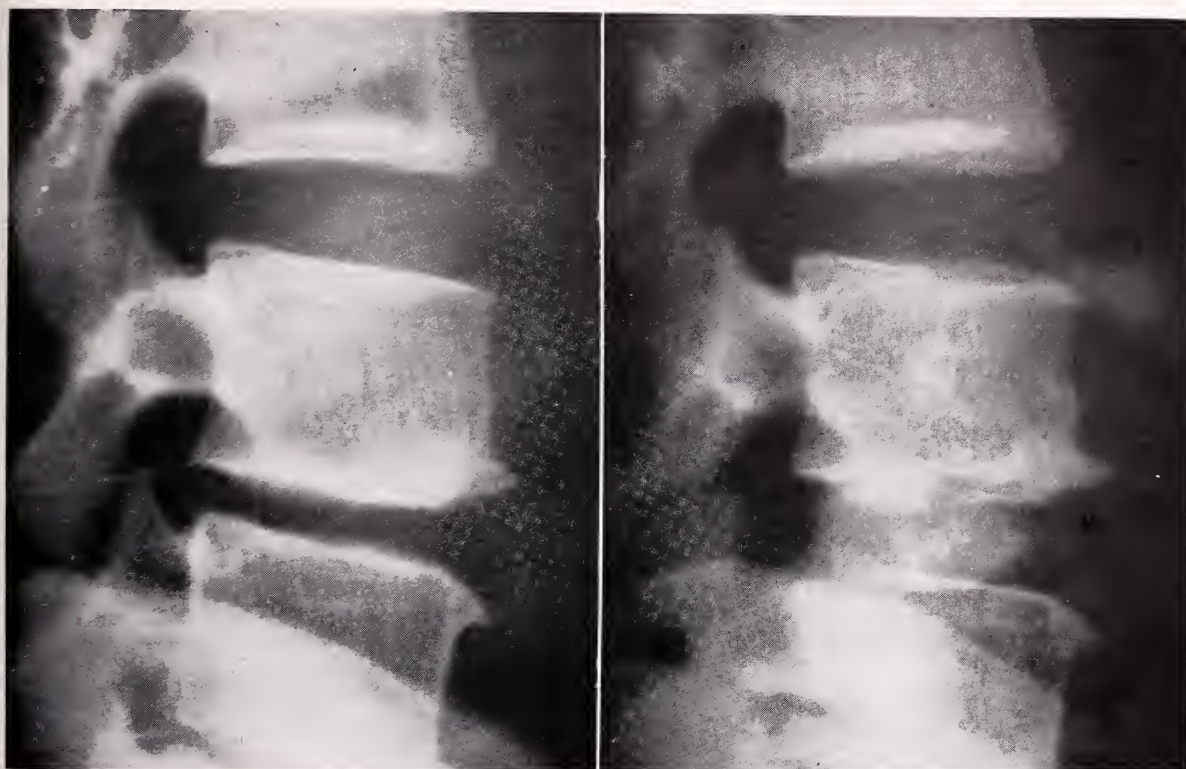


FIG. 7.—Ruptured disc at L4-5, of one year's duration. a. Note narrow intervertebral space, small intervertebral foramen and local osteophyte formation. b. Post-operative x-ray after removal of degenerated disc and replacing with four bone plugs for vertebral body fusion. Note widened intervertebral space.

zation (ward rates) which included x-rays, myelograms, operating room, anesthetist, medication and board and room was \$470.45 for the average patient in 1948, compared to \$278.50 for the patient in 1951. These figures are based upon a fixed per diem rate. A saving of over \$250.00 is attributed to a reduction in operative time, a shorter post-operative hospital stay and the cost of a back brace. The surgeon's fees remained the same (industrial accident fee schedule) for both groups. The average operative time for the 1948 patients was four hours and twelve minutes. In 1951 the shortest operative time was one hour and forty minutes! The early group remained in the hospital an average of 22.4 days compared to only 13.8 days in 1951. The convalescent period likewise has been reduced. Although we have not been able to review completely the 1951 cases, we have been impressed by the ability of these patients to return to their jobs at a much earlier date than in the previous years. The patient whose job does not require bending and lifting may return to work within two weeks after discharge from the hospital. We have had men doing heavy labor resume this type of work as early as two months after the operation!

### Summary

These recent improvements in the writer's surgical treatment of low back pain due to ruptured lumbar intervertebral disc have resulted in a more rapid and complete recovery rate than we or other surgeons have previously been able to realize. The excellent results observed to date in the 41 patients operated upon during 1951 can be attributed to several factors. Probably the most important is the Bone Bank. Preserved bone was used in 8 of the 43 patients operated upon during 1948, whereas 38 of the 41 patients in 1951 were fused with banked bone. A more accurate pre-operative diagnosis was possible in the latter group because of the discogram. The new instruments devised for the operation of vertebral body fusion have benefited the surgeon by increasing the ease and speed of the surgery. They have helped the patient by eliminating the dangers of injury to the nervous system, reducing post-operative pain and other complications. This has reduced the period of disability following the surgery and has lessened considerably the expense of the illness both in time off from work and the cost of hospitalization.

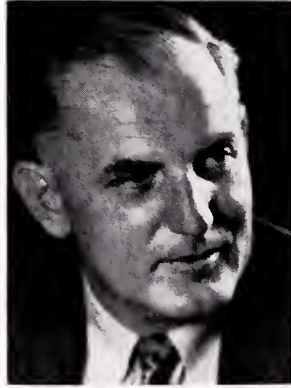


# The Conduct of Premature Labor

H. E. BOWLES, M.D.\*

HONOLULU

RECENT reviews of the case histories of neonatal deaths in the Territory of Hawaii by the Maternal and Neonatal Death Study Committee of the Hawaii Territorial Medical Association show clearly that whereas there has been a marked drop in the maternal death rate, and a less marked but definite drop in neonatal deaths in the term births, there has been no great improvement in the salvage of the premature infant. It is true that excellent equipment has been added to our premature nurseries, and that demonstration centers for the care of the premature infant have helped some, as is shown by a graph in Eastman's revision of Williams' Obstetrics.<sup>1</sup> This graph and another on the preceding page were compiled by the U. S. Children's Bureau from data obtained by the National Office of Vital Statistics.



DR. BOWLES

## Prevention of Prematurity

The appalling fact must be faced that the majority of neonatal deaths occur in the first day of life, and that most of those who die are immature infants. It should be obvious without too much thinking, then, that we must concentrate on reducing the number of immature infants by keeping them in the mother's uterus longer. This, of course, is so only if the mother is in good general health, and if the uterus itself is a fit home for the unborn child.

Among the factors that may contribute to premature emptying of the gravid uterus are malnutrition, emotional and psychic maladjustments, exposure to industrial fumes, drug addiction including alcoholism, excessive coitus, physical exhaustion, malposition of the uterus, pelvic tumors and constitutional disease, including diabetes, syphilis, heart disease, hypothyroidism and hyperthyroidism. Prophylaxis should be aimed at

control of the predisposing factor. The woman who aborts repeatedly without known cause may be given progestin or estrogen therapy. Opinion is divided as to its value here or later in gestation when premature labor has set in with or without rupture of the amniotic sac. In general one can say that at least there is no narcosis of the infant as would be the case with heavy sedation in an attempt to knock out uterine contraction. Although some mention has been made lately of occasional cases of agranulocytosis in the mother from large doses of stilbestrol, there is no apparent undesirable effect on the fetus. Happiness and a feeling of security are important in women who have aborted time after time, or in whom premature labor is threatened; hence if it will contribute to the mother's feeling of security, even though we lack definite proof that the gestation will be prolonged by the progestin or estrogen, it may be recommended. In the case of poverty and worries of various sorts in the economically underprivileged classes, the help of community agencies in relief of social and economic problems may be of great value.

## Conduct of Premature Labor

If the mother's nutrition, her general state of health, the condition of the uterus (as evidenced by its position and tone, and the presence or absence of tumors) have all received adequate attention, what can we concentrate upon next in neonatal salvage of the immature infant, other than the best possible physical equipment? Suppose that despite all our careful ante-partum supervision labor sets in prematurely. What can we do now to save the baby?

The following suggestions are offered in the hope that they may save more premature babies in the Territory of Hawaii:

1. *Avoid all but minimal sedation.* This is a tall order, as many of these mothers are nervous and have aborted before. A study of our records of neonatal deaths in Hawaii has revealed all too often that morphine or other powerful sedatives have been given the mother prior to the delivery in a mistaken attempt to stop labor. Most mothers will cooperate when the reason for the avoidance of sedation is carefully explained to them. Every-one practicing obstetrics should read Lund's ex-

\* Chief Consultant in Obstetrics, Bureau of Maternal and Child Health, Territorial Department of Health.

Received for publication December 10, 1951.

<sup>1</sup> Eastman, N. J.: Williams Obstetrics. 10th Ed., p. 12, 1950, New York; Appleton-Century-Crofts, Inc.

cellent article on the "Choice of Analgesics During Labor".<sup>2</sup> The basic principles and pharmacologic action of the analgesics and anesthetics are also well presented by Orkin and Rovenstine<sup>3</sup> and should be read by all who do obstetrical work.

2. *Give the mother supportive supervision.* This does not mean that she must be physically examined continuously from the moment that she sets foot in the hospital. When the labor room facilities permit, much anxiety can be allayed by permitting some stable member of the patient's family to be present with her in the early stage of labor. She should be encouraged to do light reading, knitting, etc. and to regard labor as a physiologic process.

3. *Progress of labor should be watched more by general observation than by dependence on rectal or vaginal examinations.* There is more chance of injury to the child, especially if it is small, than in the term labor. Regular examination and recording of findings in regard to fetal heart tones, strength of uterine contractions, etc. by competent delivery and labor room nurses or resident physician are extremely important. There must be an adequate number of attendants present at all times. Findings should always be recorded on the patient's chart. Frequent changes of position and back massage are often of great help in increasing the physical comfort of the parturient.

The presence of an unusual amount of vaginal bleeding, meconium, distention, unusual tenseness, or pain in the abdomen is of tremendous prognostic significance and must be noted.

4. *Nutrition of the woman in labor is of great importance.* The stomach of a woman in active labor does not tolerate solids well. A woman who goes into labor in a state of hunger is particularly likely to become fatigued. An excellent program of feeding for the mother in labor and in the puerperium has been outlined by the U. S. Children's Bureau with the cooperation of the Bureau's Obstetric Consultant.<sup>4</sup> In cases of prolonged labor the stomach often will not even tolerate liquids by mouth. Here, appropriate intravenous solutions should be administered in order to maintain body energy and to prevent dehydration and acidosis.

5. *Delivery of the mother in premature labor.* Certain basic principles must be adhered to if the baby is to be given the best possible chance of life.

(a) As little analgesia or anesthesia as possible, preferably none. This has been discussed earlier

in this paper. Eastman<sup>5</sup> feels that no form of analgesia except continuous caudal or spinal anesthesia should be given and that delivery should be effected by caudal, spinal, or local infiltration anesthesia. After a liberal episiotomy has been made, oxygen inhalation in the second stage of labor is often of value in improving the respirations of the newborn premature. It is not unusual to note that the mother relaxes better with the uterine contractions during the inhalation of the oxygen.

(b) Actual delivery. When the premature fetus presents by the vertex, simple fundal pressure accompanied by an episiotomy is the method of choice. Episiotomy may not be needed if the outlet is relaxed. The head should not be compressed by the obstetrical forceps. The delivery of the premature breech fetus is fraught with far greater danger than is the case with the full-term fetus. Occasionally Dührssen's slits may be needed when the cervix constricts the child's neck and the neck may easily be injured.

The cord should be cut only after its contained vessels cease to pulsate. An immature infant needs the extra blood thus obtained even more than does a term baby.

#### Resuscitation of the Premature Infant

As emphasized by Eastman,<sup>6</sup> a clear airway, oxygen, warmth, and as little handling as possible are the most important aids to resuscitation in neonatal asphyxia. Aspiration must be extremely gentle. The physiology of respiration in the newborn is well analyzed by Fletcher and Rogers.<sup>7</sup> Occasionally nothing that we can do will cause the lungs of a premature baby to expand. Behrle<sup>8</sup> and colleagues have shown that lungs containing extensive hyaline membranes cannot be satisfactorily expanded. Miller<sup>9</sup> has shown that a great many prematures have these troublesome hyaline membranes. Neither can the lungs of infants who weigh less than 1200 grams be expanded to the degree obtained in larger infants.

Bloxson<sup>10</sup> has introduced a new method of resuscitation carried out in a most ingenious machine operating under the positive-pressure principle. It is too early yet to know much about results obtained with this apparatus as compared with older techniques. It may prove of great value.

<sup>5</sup> Eastman,<sup>1</sup> p. 498.

<sup>6</sup> Eastman,<sup>1</sup> p. 499.

<sup>7</sup> Fletcher, J. P., and Rogers, J. W.: Resuscitation of the Newborn, J.A.M.A. 145:533 (Feb. 24) 1951.

<sup>8</sup> Behrle, F. C., Gibson, D. M., and Miller, H. C.: Expansion of Lungs of Newborn Infants, Pediatrics 7:782 (June) 1951.

<sup>9</sup> Miller, H. C., and Jennison, M. H.: Study of Pulmonary Hyaline-Like Material in 4117 Consecutive Births, Pediatrics 5:7 (Jan.) 1950.

<sup>10</sup> Bloxson, A.: Asphyxia Neonatorum, J.A.M.A. 146:1120 (July 21) 1951.

<sup>2</sup> Lund, C. J.: Choice of Analgesics During First Stage of Labor, J.A.M.A. 145:1114 (Apr. 14) 1951.

<sup>3</sup> Orkin, L. R., and Rovenstine, E. A.: Obstetrical Analgesia and Anesthesia, Med. Clin. North Amer. 35:805 (May) 1951.

<sup>4</sup> U.S. Dept. of Labor, Children's Bureau. Food During Labor and the Puerperal State. The Child 9:169 (May) 1945.



It seems proper now to refer to methods or measures which are not approved for the resuscitation of the newborn and may even contribute to a fatality if applied to a newborn premature infant. They are taken from a report by the Child Health Welfare Committee and the Committee on Anesthetic Study of the King's County Medical Society, New York.<sup>11</sup> They are: (1) manual methods of artificial respiration; (2) physical stimulation other than suction of air passages; (3) chemical stimulation of respiration, e.g., caffeine, digitalis, alpha-lobelin, coramine, CO<sub>2</sub> in any percentage, etc.; (4) cardiac stimulation by drugs, e.g., digitalis, caffeine, coramine, etc.; (5) oxygen administration by any means other than face mask, e.g., funnel or nasal catheter; (6) use of positive pressure during insufflation without manual control by experienced personnel or automatic control by an approved apparatus; and (7) removal of foreign material from air passages by any means other than suction, e.g., gauze wipes, milking the trachea.

#### Care of the Premature Infant

After the child has been born, skilled pediatric care with the best possible equipment of all sorts should be available to carry the premature's life farther toward maturity. Numerous demonstration centers have been set up throughout the country for premature baby care. It is beyond the scope of this paper to go into pediatric details. It must be remembered also that twenty percent of premature babies in the United States of America die each year after they have been sent home from hospitals.

Continuous health supervision and guidance are urgently needed at this point. The parents must be acquainted with all details of necessary care, and the proper equipment and surroundings must be readied before the child arrives home. Much can be learned from communities which have already instituted successful follow-up plans.

In closing, the reader is referred to an excellent article in "Hospitals" for July 1951 by Klicka and colleagues<sup>12</sup> on a plan which has been operating successfully in the greater New York area. The importance of adequate follow-up and interagency cooperation cannot be overemphasized, for without it all previous efforts may be nullified on short order. The financial burden in the care of the premature is often colossal and the average couple often give up much needed care for this reason,

failing mainly on account of adequate follow-up.

In closing let us emphasize again the importance of avoiding prematurity whenever this is feasible, and physically possible, concentrating first of all on this phase of the problem and secondarily, when efforts have failed to hold the baby in the uterus to term, on the other factors which have been discussed.

#### Summary

1. The greatest source of neonatal deaths in the Territory of Hawaii is the premature infant group.

2. For many years there has been no appreciable decrease of deaths in neonatal premature babies.

3. The following points are suggested in an attempt to save more of these premature babies once labor has begun:

- a. Avoid all but minimal sedation;
- b. Careful supportive supervision with emphasis on allaying fear and the encouragement to participate in light diversionary activities in early labor;
- c. Careful and continuous observation by competent personnel throughout labor with special attention to vaginal bleeding, fetal heart tones, etc. Dependence on general observation rather than on rectal or vaginal examinations;
- d. Special attention to nutrition. Emphasis on liquid diet. Intravenous solutions when oral ingestion is not well tolerated or where labor is prolonged;
- e. As little analgesia or anesthesia as possible with emphasis on local, spinal or caudal techniques. Oxygen inhalation in second stage of labor;
- f. Simple fundal pressure with episiotomy when the vertex presents. Extreme care with the breech; Dührssen's slits when needed;
- g. The cord should not be cut until it stops pulsating;
- h. Resuscitation emphasis on a clear airway, 100 percent oxygen inhalation, warmth and as little handling as possible. Emphasis on gentleness.

4. A list of procedures contraindicated in resuscitation is given.

5. Adequate pediatric care with skilled personnel and special equipment now follows.

6. Emphasis is placed on a careful follow-up program using community agencies specially fitted for relief of economic sociological problems.

<sup>11</sup> Child Health and Welfare Committee, Maternal Welfare Committee, and Committee on Anesthetic Study. Prevention and Treatment of Asphyxia of the Newborn, Bull. Med. Soc. of County of Kings, May, 1949.

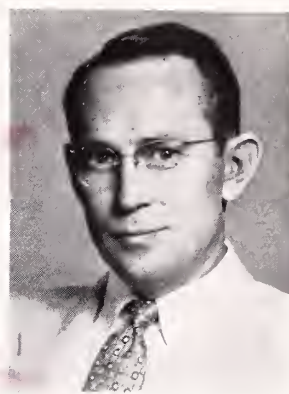
<sup>12</sup> Klicka, K. S.; Wallace, H. M.; Losty, M. A., and Donny, E. M.: A Home Follow-Up Plan for Care of Premature Infants, Hospital, 25:54 (July) 1951.

This outline was formulated at the request of the Maternal and Neonatal Death Study Committee of the Hawaii Territorial Medical Association.

1020 Kapiolani Street

# Treatment of Viral Enteritis with Vitamin B Complex

DOUGLAS H. MURRAY, M.D.  
HONOLULU



DR. MURRAY

THE PURPOSE of this paper is merely to present some observations on the results of treatment of a small series of cases of viral enteritis. It is apparent that a new epidemic of this disease is at hand; the number of cases is rising and their severity increasing. In this epidemic there seems to be less tendency toward dehydration and acidosis, and more tendency toward development of a subacute or chronic stage, than in the previous epidemic. The usual measures of control are less effective than would be normally expected.

In 1942, May McCreary and Blackfan published their results with the use of crude liver extract in combination with vitamin B complex in the treatment of celiac disease. These drugs used on alternate days over a period of two weeks

will generally bring about a cure even in the absence of diet restrictions or changes. Crude liver extract is also known to be effective in the sprue-like syndrome that occasionally follows viral diarrhea, and it may also produce dramatic relief in the acute stage. However, its use is limited in view of the extreme pain caused by the injection of the required dose (4 cc. intramuscularly for an infant).

It was with this in mind that a preparation of

Received for publication March 15, 1952.

CASE NO.	DURATION	AGE	WT.	SEX	RACE	VOMITING	LOSS OF APPE- TITE	AVERAGE NO. OF STOOLS	TYPE	DOSE	RESULTS
1	4 da.	2 yrs.	25	M	Ch.	+++	++	5-7/day	Diarrhea Liquid	2cc	Immediate recovery
2	14 da.	7 mo.	16	F	Cauc.	++	+++	Variable	Liquid (2 days)	1cc	Immediate recovery
3*	1 da.	2½ mo.	8½	F	{Ch. Haw'n	+	+++	8-10	Watery	1cc	Improved
4	1 da.	21 mo.	21	M	{Jap. Fil.	0	+++	6-8	Watery	2cc	All symptoms stopped immediately
5**	8 hrs.	7 mo.	17	F	Port.	++	+++	2	Watery	1cc	Immediate O.K.*
6	2 da.	15 mo.	23	F	Haw'n	+++	+++	?	Liquid	2cc	Immediate O.K.
7	4 da.	16 mo.	24	M	{Haw'n Jap.	+++	+++	4	Liquid	2cc	Recovery in 8 hours
8	4 da.	21 mo.	30	M	Haw'n	++	Yes	6-8	Liquid	2cc	Recovery immediately
9†	2 hrs.	6 mo.	20	M	{Haw'n Jap.	++	Yes	0	.....	1cc	No further symptoms
10‡	6 da.	3 mo.	13	M	Cauc.	0	Yes	9	Liquid	1cc	See note
11	3 da.	7 mo.	14	F	Jap.	+++	Yes	8-10	Liquid	1cc	Recovery immediately
12	4 da.	2½ yrs.	30	F	Cauc.	+++	Yes	4-6	Liquid	2cc	Recovery immediately
13§	4 da.	5 mo.	15	M	{Haw'n Cauc.	0	Yes	4-5	Liquid	1cc	See note
14	3 da.	6 yrs.	47	M	Fil.	++	Yes	Many	Liquid	2cc	1 loose stool after 8 hours
15	5 da.	9 yrs.		M	Cauc.	0	Yes	4-5	Large semi-liq	2cc	Immediate full
16	7 da.	21 mo.		M	Cauc.	0	0	8-10	Liquid	2cc	Immediate
17	5 da.	7½ mo.		M	Cauc.	+++	Yes	6-5	Liquid	2cc	Pau immediate

\* This child weighed 5 lb. 12 oz. at birth and had been a "feeding problem" since. A diagnosis of gastro-intestinal allergy had been established and she had had frequent attacks of diarrhea and vomiting prior to this. Diagnosis of viral enteritis was not absolutely established. Definite improvement was noticed without change of diet.

\*\* The first "acute" phase treated.

† Child was discharged as cured one day previously from a severe pneumonitis and was brought to the office in the morning, having vomited all feedings that morning. This was called a prophylactic dose!

‡ Another "feeding problem" with typical symptoms in addition. The appetite returned to normal immediately but he had more loose stools on the second day with subsequent recovery on further restriction of diet.

§ One loose stool per day for 2 days but appetite returned immediately.



vitamin B complex, Folbesyn,\* was tried on two cases which presented this sprue-like syndrome in mild degree. The first case had shown the typical symptoms of viral enteritis and had been treated in the usual manner with the result that the vomiting had stopped after the first few hours, but he had continued to pass 4 to 5 large watery stools per day and showed an almost total loss of appetite. Following an injection of 2 cc. of Folbesyn there was an immediate cessation of the abnormal stools and an immediate return of the appetite. The mother of this patient reported, however, that he cried and held his hand over the site of injection for an hour. In this connection it has been shown that solution of the crystals must be obtained by flushing the ampule with the diluent. Shaking only will result in incomplete solution and subsequent pain.

The second case had run the gamut of the acute phase and had been treated in the usual manner. Following this she had continued for two weeks to have one or two large, loose, foul-smelling stools per day and had been averaging only 12 to 14 ounces of formula with a total loss of appetite for solid foods. She was very restless, slept

poorly, and only for short periods of time. Folbesyn, 1 cc., was given at 4 p.m. The mother reported the following day that at 5 p.m., the child took a full feeding, including her usual solids plus 8 ounces of formula, and then, for the first time in two weeks, slept all night, and the following morning demanded 8 ounces of formula at 7 a.m. and again at 10 a.m. Recovery was complete.

Following this, the drug was given in a succession of cases, the highlights of which are given in the accompanying table. Four cases in this series have been omitted in this table, since no reports were given by the patients' mothers. The fact that the requested reports were not forthcoming may or may not mean that the results were favorable.

### Comment

This report is totally lacking in controls. This treatment has been used in an occasional case seen during the past year, as well as those in the present epidemic, and the results have served to strengthen the impression that in this we have a drug which offers a better approach to a problem that had frequently been difficult to manage.

\* Lederle. Each cc. contains 10 mg. B<sub>1</sub>, B<sub>2</sub> and sodium pantothenate; 5 mg. B<sub>6</sub>; 50 mg. niacinamide; 300 mg. C; and 15 mcg. B<sub>12</sub>. The diluent contains folic acid, 3 mg. per cc.

# Sclerosing Lipogranuloma

## Case Report

DOUGLAS H. BELL, M.D., AND W. HAROLD CIVIN, M.D.

HONOLULU

THIS INTERESTING granulomatous reaction that occurs after injury in subcutaneous fat was unknown to the senior author until tissue from the case to be reported was submitted for study. Apparently, several clinical entities of fat necrosis have been studied and recognized. Smetana and Bernhard in their comprehensive article on the subject in the Sept., 1950 issue of the *Archives of Pathology*, mentioned traumatic fat necrosis, Weber-Christian disease or relapsing febrile non-suppurative nodular panniculitis, adiponecrosis subcutanea neonatorum, calcinosis, and change in the lung parenchyma following aspiration of oils and fats. Material for study has been obtained from the genital region, the buttocks, the extremities and the orbit, and the pathological features were the same. Smetana and Bernhard chose the name sclerosing lipogranuloma after studying fourteen cases at Armed Forces Institute of Pathology. They considered this name as descriptive of the basic pathological characteristics. Their material was varied but in all cases there was mention of tenderness and swelling which persisted, sometimes for years. The type of injury was variable, from blows to bites to kicks to surgical incisions. Preoperative diagnosis varied from tumor to abscess. Without surgery, in no case was there complete spontaneous healing even after many years.

The cause of this peculiar reaction in fat is not clear. In Weber-Christian disease there is fever and a relapsing course which suggests a systemic inflammatory disease. However, in sclerosing lipogranuloma the local reaction is related to regional injury. The histologic similarities of the two diseases are striking and can be mimicked by the tissue reaction caused by the introduction of lipid materials. The assumption that formation of fatty acids is essential in the genesis of lipogranuloma is probably erroneous.

### Case Report

The history of the case to be reported follows. At age seventeen, in March, 1932, she underwent an appendectomy and right ovariectomy through a right rectus incision. Recovery was uneventful and the wound healed primarily. In October 1934, she gave birth to twins.

On September 30, 1935, through a midline incision, a left ovarian cyst was resected and a suspension operation on the uterus was done. Wound healing and convalescence were normal. In December, 1943, Dr. R. O. Brown did a cystoscopic examination and catheterized the left ureter. The ureter was dilated. This was thought to be the cause of frequency and dysuria. On June 10, 1944, lysis of small bowel adhesions was done and a hysterectomy performed through a midline incision. The wound healed by primary intention. On September 8, 1948, cystoscopic and bilateral catheterization was done for frequent and urgent urination. This study was repeated on September 30, 1949. A Hunner's ulcer was suspected but not positively proven.

On November 24, 1950, through a long left rectus incision, after prior cystoscopy and catheterization of the left ureter, the left ureter was explored and adhesions between anterior wall and omentum and small and large bowel were separated. Wound healing occurred per primum. The patient went home on the ninth day. On December 12, 1950, dressing was done at the office. The wound was exquisitely tender and warm. It was probed for possible abscess. None was found.

On January 3, 1951, an incision was made into rather firm subcutaneous tissue. It was expected that this incision would uncover pus. None was found, but the fat was firm and gray-yellow. A good section of this fat was excised and taken to the pathologist for study. The excision of this tissue relieved pain greatly. Dr. Civin reported the tissue as being sclerosing lipogranuloma. On February 1, 1951, because of continued pain, another fair sized piece of subcutaneous tissue was excised. There was great relief from pain until April 3 when a new area of thickening in the incision was noted. Ten cc. of Metycaine was injected with some relief. On May 9, 1951, the area was chilled by spraying with ethyl chloride. In September acute soreness recurred along the lateral lower side of the incision. Ten cc. of Metycaine was injected into the area on several occasions. The pain seemed to be along the course of the ilio-inguinal nerve. Because of the repeated episodes of pain and tenderness and repeated excisions, Dr. Thomas Bennett saw her with the idea of doing a neurectomy to control pain.

On September 6, 1951, the patient was admitted to The Queen's Hospital because of exquisite tenderness in the left rectus incision and along the course of the ilio-inguinal nerve. An excision of 8 x 4 x 4 cm. of involved fat tissue at the lower angle of wound was done. Pain subsided almost immediately. Wound healing, after removal of drain, was immediate and good. On October 1, 1951, a 5 x 5 cm. area of fat on the medial side of the incision was resected.

Since this last excision there has been no recurrence. It should be explained that each time excision was done, the whole of involved tissue was apparently excised.



The very exquisite tenderness of the involved area in this case was remarkable. It is also noteworthy that there was never evidence of infection in any of the surgically excised areas. All healing of skin was per primum. All laboratory studies, such as blood counts and urinalyses, were normal.

Grossly, the tissue first removed was a firm grayish-yellow non-circumscribed mass of fatty and fibrous tissue received in two pieces, each measuring 3.5 x 2.5 x 1 cm.

Histological sections showed disruption and alteration of fat lobules of the subcutaneous tissue. Many fat cells showed necrosis manifested by accumulation of stainable material in the cell. Fusion of fat globules, with the production of giant droplets similar to the "fatty cysts" described by Hartroft in the liver, were seen. These large droplets were often surrounded by continuous rows of spindle shaped nuclei or by foreign body giant cells. An eosinophilic hyaline substance replaced normal fat septa. Focal lymphocytic infiltration was present. Fibrosis was marked in areas. A granulomatous reaction was also noted in the dermis.

Each subsequent removal furnished tissue more or less resembling the first tissue removed. The features presented by the material from this patient are well documented in the general description of the process given by Smetana and Bernhard. All phases of granulomatosis and sclerosis are seen. One of us, (WHC), had previously been accustomed to referring to this condition as lipoid granuloma. Because of the diversity of names and findings in this process, we have adopted the nomenclature of Smetana and Bernhard, since it represents an attempt to clarify the picture and standardize the terminology.

### Discussion

The occurrence of the lesion in the abdomen brought up the problem of relapsing febrile non-suppurative nodular panniculitis in the differen-

tial diagnosis. Smetana states that in his experience the involvement in this latter condition is chiefly septal. On the other hand Allen feels that the septa are relatively spared. In the case discussed here, contrariwise, the involvement was both septal and lobular. Furthermore, Lever states that foreign body giant cells are not seen in Weber-Christian disease. Here they were found. Of course, the previous surgery may have stimulated them. However, the chief reasons which would exclude the diagnosis of Weber-Christian disease are furnished by the history and clinical course. The history of surgical intervention, the absence of fever, and the localization to the traumatized area, all tend to establish this case as one of sclerosing lipogranuloma. The chronicity and recurrence of the process do not negate this diagnosis since Smetana observed several such cases wherein the existence of Weber-Christian disease was most improbable.

This case would seem to be added evidence for Smetana's concept that sclerosing lipogranuloma is a reactive process which sometimes follows injury of varying character to the subcutaneous tissue. The injury probably sets off the reaction by only temporarily interfering with the local blood supply and fat metabolism. The condition is probably more common than is generally realized and would seem to be in certain cases an unavoidable complication of surgery.

---

Dillingham Bldg. (D.B.B.)  
The Queen's Hospital (W.H.C.)

# Prime Factor in Convalescence



*---a prominent  
visitor  
points it up*

"I have been in and out of hospitals on and off for some time, but I don't believe that I was ever in a place where my stay was made so pleasant. The little personal touches point to an unusual sensitivity to the patient's needs.

"You have a fine, loyal, interested staff . . . As you know, I am sensitive to people's reactions especially as they work together. The fine morale of your folks was evident at every turn."

(Signed) Hiram S. Hall  
Industry Board Member

Mr. Hall is a member of the Wage Stabilization Board. On a recent visit to Honolulu he was a patient for several weeks at the Convalescent Nursing Home.

His letter points up the basic purpose of this institution—to provide every facility for superior nursing care—second only to medical supervision as a factor in convalescent progress.

In a superb setting, the Convalescent Nursing Home is ideally situated for its purpose — within a 20-minute drive from downtown Honolulu. Its rates, as low as \$5 per day, make its facilities suitable to a wide range of patients.

## CONVALESCENT NURSING HOME

5115 Maunalani Circle • Telephone 7-1981





## *The President's Page*

The chairmen and members of the Standing Committees of the Hawaii Territorial Medical Association have made the past year a creditable and constructive one for the organization. As your President, during this year, I can and do take pride in what they have accomplished; the credit for it is all theirs.

The press-radio-relations dinner meeting organized and conducted by Ike Kawasaki and his Public Service Committee; the child care radio program to be conducted by Larry Stevens of KGMB, preliminary plans for which were worked out under Tell Nelson and his Health Education Committee; the unusually good Annual Meeting program arranged by Morton Berk and his Scientific Works Committee; the vigorous program, including an outstanding postgraduate lecturer, Dr. William Boyd, conducted by the Cancer Committee under Grover Batten and the joint County-Territorial Postgraduate Committee under Verne Waite; the pioneering and arduous exploratory work accomplished by the Advisory Committee on Chronic Illness under Shoyei Yamauchi's leadership; the constructive plans proposed (for later definitive action) by the smallest committee, that on By-Laws Revision, consisting only of the Chairman, Frick Nance; these are the highlights, among many other accomplishments that cannot be listed here, of the Association's accomplishments during the year. Topping off the series, chronologically speaking, were Ed Chung-Hoon's sound husbandry of our funds, including a balanced budget for the coming year, and Bill Walsh's outstanding job in planning and conducting one of the best Annual Meetings most of us could recall.

It has been a pleasure, and a great privilege, to have served the Association as your President this past year. It is no less a pleasure, however, to turn the job over to Jiggs McArthur and his assistant and eventual successor, Ed Chung-Hoon. I am confident they will enjoy it as much as I did. Thank you all!

*Henry H. H. H.*

# Hawaii

## MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D. Editor  
MRS. EDITH C. BENNETT Managing Editor  
WILLIAM JOHN HOLMES, M.D. News Editor  
HASTINGS H. WALKER, M.D. Advisory Board  
HOMER IZUMI, M.D. Advisory Board  
PETE OKUMOTO, M.D. Associate Editor, Hawaii  
EDWARD S. KUSHI, M.D. Associate Editor, Maui  
C. H. ISHII, M.D. Associate Editor, Kauai

### [ EDITORIALS ]

#### EPIDEMIC HEMORRHAGIC FEVER

The challenge of a "new" disease, epidemic hemorrhagic fever, was initially presented to the United States Army in 1951 by an outbreak in a limited area of the Korean battlefield. The Japanese Army had encountered the same problem in Manchuria in the 1930's, called the disease Songo Fever, and did extensive investigative work. They reported the cause to be a virus, transmitted by the mite *Laelaps jettmari* Vitzthun, an inhabitant of rodents and grasses; that the disease had a spring and fall peak of incidence; and that it was best treated by convalescent serum. To date, the U. S. Army has been unable to confirm these reports.

The disease is physiologically one of capillary fragility, produced by an as yet unknown factor. A virus with a specificity for endothelial cells would seem to be the best explanation at the present time and would account for the severe systemic reaction of onset (viremia), the phase of hemorrhage (endothelial damage) and the phase of recovery (capillary repair). That the disease is due to an infective agent seems plausible, since native populations possess natural immunity.

The bizarre pathological picture is basically one of hemorrhage, both petechial and gross, and its end results. Any tissue or site may be involved, although there are two outstandingly characteristic findings, seen only in this disease: marked sub-endothelial hemorrhage sharply limited to the right auricle, and marked intertubular hemorrhage sharply limited to the medullary renal pyramids. The GI tract shows congestion throughout its entire length, the lungs show interstitial edema, and the pituitary and adrenal frequently show hemorrhage.

After an invasive phase, indistinguishable from other acute febrile diseases, the hemorrhagic phase is heralded by onset of hematuria, albuminuria and petechiae. Vomiting, cough and hiccough are often severe and seem to induce the gross hemorrhage, principally hemoptysis, hematemesis, and bloody diarrhea. More characteristic, however, are ecchymoses and the extensive episcleral hemorrhages, the "red eye." The heart may show signs of involvement, the lungs engorgement. Oliguria with increasing azotemia mark the renal trend. Convalescence is like the recovery phase of lower nephron nephrosis.

The laboratory findings too are bizarre: hemoconcentration, very high leucocyte counts and sedimentation rates, low platelet counts, prolonged bleeding time, and high NPN. Bone marrow, liver function, prothrombin time, clotting time, and agglutinations are within normal ranges.

Practically the entire spectrum of applicable drugs have been exhibited in treatment, none successfully. Antibiotics, corticotropin (ACTH), cortisone and transfusions seem to be of no value. The most successful regimen has been symptomatic relief, bed rest, good nursing care, and sedation, with particular emphasis on the latter. The efficacy of convalescent serum is yet to be proven.

Prognosis is in general good for both recovery and escape from residuals. Fatality rate is between six and seven percent. Death is usually due to uremia plus other factors such as hemorrhage, pulmonary edema or cardiac failure.

In handling this "exotic" oriental disease, top effort has been applied both in research and patient care. The very low fatality rate is entirely due to the devoted hard work, interest and ingenuity



of the American physicians in uniform who were able to adapt to and think through the unknown with which they were faced. As a result, the clinical aspects as well as the pathology have been well documented and work continues on the cause, vector and mode of transmission. In anticipation of a possible spring outbreak, markedly stepped up rodent and insect control programs are being carried out and research teams are preparing for a concentrated effort to determine optimum and if possible specific therapy. Needless to say the challenge presented has been accepted in the characteristic fashion of American medicine.

CHARLES L. LEEDHAM, Colonel, M.C.  
*Consultant, Internal Medicine*  
*Far East Command, U. S. Army*

### HOW GOOD IS ISONICOTINIC ACID HYDRAZIDE?

Isonicotinic acid hydrazide isn't a new drug—it has been in use in Europe for nearly two years. It is a wonder drug only in the sense that we wonder how good it really is—we don't know, yet. Marketed as "Nydrazid" by Squibb, and as "Rimifon" by Hoffman-La Roche—and, as an isopropyl derivative, as "Marsilid" (also by Hoffman-La Roche)—it is now under extensive trial against tuberculosis in this country, and under very limited trial against leprosy.

These drugs are effective against *M. tuberculosis* in vitro in concentrations as low as 0.02 micrograms per milliliter, and against practically nothing else. In animals they seem about as effective as streptomycin. The question of emergence of resistant strains is still an open one; BCG, at least, can become resistant to them.

The usual dose is 150 to 300 mg. daily for the average adult, given orally in two or three divided doses, or parenterally. Toxicity is incompletely explored as yet; transitory constipation, hyperreflexia, hypotensive dizziness, eosinophilia, and albuminuria are the principal effects observed to date, and they are infrequent.

Clinical effectiveness is also incompletely evaluated, though reduction of fever within 2 or 3 weeks, reduction in cough and sputum-volume, gains in appetite, weight and strength, and some improvement in x-ray findings and clearing of visible lesions, have been observed in the majority of patients.

Mechanism of action of the drug is unknown; optimal dosage remains to be determined; duration of therapy is unsettled; likelihood of relapse has not been determined; possibility of modifying

basic treatment has yet to be explored. So far there is no basis for altering the presently accepted principles of treatment of tuberculosis because of the advent of these preparations. The excitement created by the seemingly spectacular improvement (chiefly in sense of well-being) of the first treated cases has now subsided, and in the cool light of reality, we can now see that all we have is some promising new drugs which will have to be appraised before they can be praised.

### THANKS TO CANCER SOCIETY AND TUBERCULOSIS ASSOCIATION

A service to the people of all the Islands, which should be particularly appreciated by the doctors of Hawaii, has been rendered by the Hawaii Cancer Society and the Oahu Tuberculosis and Health Association by the action of these two organizations in bringing two outstanding medical educators, Dr. William Boyd of Vancouver, and Dr. Howard Bosworth of Los Angeles, to Hawaii.

This is the first time that the burden of financing postgraduate medical lectures—and a guest speaker at the annual meeting at the Territorial Association—has been lifted from the shoulders and the pocketbooks of the members of the Honolulu County Medical Society. For many years past, they have annually financed this rather expensive program. It seems altogether appropriate that it should be taken over by these organizations working in the health field, for certainly professional education is a highly important enterprise and an essential part of their respective programs.

We would be happy to see this efficient and cooperative arrangement continued in future years, and we would like to assure the members of the Cancer Society and the Tuberculosis and Health Association that we feel the money is very well spent, indeed, and that we are grateful to them.

### ASSOCIATE MEMBERS TAKE NOTICE

Associate Members of the Honolulu County Medical Society are automatically Associate Members of the American Medical Association. Their only dues are the \$10.00 a year to be paid to the County Society; no additional Territorial or National dues are charged against them.

This statement corrects an error in our Editorial Page (Page 226) of the March-April issue of the HAWAII MEDICAL JOURNAL to the effect that "Associate Members cannot join the AMA at all." The fact is that Associate Members cannot be regular members of AMA unless they are entitled to Service Fellowship by reason of being in Military Service.

# THIS IS WHAT'S NEW!

Gofman and associates reiterate their (controversial) assertions concerning the effectiveness of a **low fat, low cholesterol diet** in lowering the blood level of SF 10-20 lipoprotein molecules, and in retarding the progress of **coronary atherosclerosis**. (*Arch. Int. Med.* 89:421 [Mar.] 1952.) This time they back up their stand with a twelve to eighteen month follow-up study of lipoprotein levels and recurrence of myocardial infarctions in patients who dieted and those who did not. Also restated is the remarkable action of heparin in drastically lowering lipoprotein levels and relieving angina pectoris.

So simple a step into the millennium! Some view Gofman's work as Nobel-Prize stuff; others much more dimly.

Note of caution: both **ACTH** and **cortisone** regularly produce **abortion** in mice and rabbits (Robson and Sharaf, *J. Physiol.* 116:236 [Feb.] 1952). The wonder hormones have been (relatively) contraindicated in pregnancy heretofore because of their salt retaining and hypertensive propensities.

**Aureomycin calcium caseinate** was tried by Manning and Wellman in 24 patients, 6 of whom had had **nausea and vomiting** while on plain aureomycin. Only one patient vomited (turned out later to have psychogenic vomiting, even after off all medication for weeks), and 3 were nauseated with the new preparation. Each tablet contains 125 mg. aureomycin calcium caseinate, 200 mg. calcium caseinate, and 50 mg. calcium carbonate. Blood levels were identical to those with plain aureomycin, using weight-equivalent doses. (*Proc. Staff Meet. Mayo Clin.* 27:89 [Feb. 27] 1952.)

Granirer's results in treating **rheumatoid arthritis** with postpartum plasma are being bettered by Aronsson, et al., using **placental serum**. With a needle in the umbilical vein and a suction bottle, an average of 70 cc. of serum can be obtained from a human placenta a few seconds after delivery. This is pooled, and 10 cc. is given intramuscularly twice weekly. Improvement in 85 per cent of 35 patients began in three to four weeks and continued as long as injections were continued. (*Am. J. Med. Sci.* 223:144 [Feb.] 1952.) The active agent is unknown. It is estimated that each 250 cc. dose of Granirer's postpartum plasma contains 0.1 mg. of ACTH (shades of homeopathy!).

There has never been a specific antidote for morphine poisoning. Eckenhoff, et al., report on the use of **N-allyl-normorphine** as a **morphine and demerol antidote**. (*Am. J. Med. Sci.* 223:191 [Feb.] 1952.) This drug has been

(slightly) investigated since 1941 and the results are not breathtaking. Already marketed as "Nalline" (Merck).

New study of an old medicine: **pancreatin** in totally gastrectomized dogs proved to be ineffective in reducing fecal fat loss, but significantly **increased nitrogen retention**. (Everson, *Ann. Surg.* 135:406 [Mar.] 1952.)

**Mephenesin** ("Tolserol") is useful in controlling **spasticity and hyperkinesis**, but shortness of action makes large doses at frequent intervals necessary. Dresel and Slater are on the track of a modified mephenesin which has longer duration of action, with similar potency. (*Proc. Soc. Exp. Biol. & Med.* 79:286 [Feb.] 1952.)

**Non-mercurial diuretics** are being explored by Kattus, et al. (*Am. J. Med.* 12:319 [Mar.] 1952). Xanthines more potent than the ones in common use proved to be emetic. Two derivatives of the uracil nucleus hold promise, however: 1-propyl-3-ethyl-6-aminouracil, and 1-allyl-3-ethyl-6-aminouracil. Optimum dosage seems to be 1 gm./day, and diuresis is better than that following aminophyllin and not quite as good as that obtained with thimerin.

Take the urine of a pregnant mare, extract the water and the estrogens, and the dry stuff which is left is "**marisone**" (Ayerst, McKenna & Harrison). Duemling and Millman (*Arch. Derm. & Syphilol.* 65:327 [Mar.] 1952) tried it as a cheap **substitute for cortisone** in 22 patients with assorted dermatoses. They found that this "natural steroid complex" was decidedly helpful in pemphigus, contact dermatitis, keratoderma climacterium, atopic dermatitis, neurodermatitis, and psoriasis. It was a flat failure in discoid L.E., seborrheic dermatitis, and urticaria. Side-effects (estrogenic) consisted of vaginal bleeding and tender breasts.

Much ado about **invert sugar** ("Travert"-Baxter) seems more and more firmly established on sound facts, not just advertising. Miller, et al. present careful studies which show that fructose is phosphorylated by a different hexokinase than is glucose and is therefore **utilized by the diabetic** as well as by the normal individual, even without insulin. (*J. Clin. Invest.* 31:115 [Jan.] 1952.)

**Furacin vaginal suppositories** are regarded as an ideal antibiotic in pre- and postoperative treatment of the cervix and vagina by Schwartz. (*Am. J. Obst. & Gynec.* 63:579 [Mar.] 1952.)

C. A. DOMZALSKI, JR., M.D.



# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*

MRS. FLORENCE GRAY, *Assistant Librarian*

Phone 65370

8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.

Monday through Friday

Closed Saturdays at noon and Sundays

Closed all day and evening on National holidays  
and at noon on Territorial holidays

---

## Recent Acquisitions

### Anatomy

Lockhart, R. D. *Living anatomy*. 2nd ed. c1950.

### Biochemistry

Mackenzie, C. G., ed. *Biological antioxidants*. Transactions . . . 5th conference, Nov. 30—Dec. 1, 1950. c1951. (gift of Josiah Macy, Jr. Foundation)

Reifenstein, E. C., ed. *Metabolic interrelations*. Transactions . . . 3rd conference, Jan. 8/9, 1951. c1951. (gift of Josiah Macy, Jr. Foundation)

### Cancer

Davidson, Maurice. *The diagnosis and treatment of intrathoracic new growths*. 1951.

Eller, J. J. *Tumors of the skin*. 2nd ed. rev. & enl. c1951.

Hartwell, J. L. *Survey of compounds which have been tested for carcinogenic activity*. 2nd ed. 1951. (gift of the Federal Security Agency)

Murphy, D. P. *Heredity in uterine cancer*. c1952.

### Digestive System

Hoffbauer, F. W., ed. *Liver injury*. Transactions . . . 10th conference, May 21/22, 1951. c1951. (gift of Josiah Macy, Jr. Foundation)

Thomas, J. E. *The external secretion of the pancreas*. c1950. (gift of publisher)

### Drugs

Howard, M. E., ed. *Modern drug encyclopedia*. 5th ed. c1952.

Smith, L. W. *Penicillin decade (1941-1951)*. c1951. (gift of publisher)

### Electrocardiography

Ziegler, R. F. *Electrocardiographic studies in normal infants and children*. c1951. (gift of publisher)

### Hematology

Flynn, J. E., ed. *Blood clotting and allied problems*. Transactions . . . 4th conference, Jan. 22/23, 1951. c1951. (gift of Josiah Macy, Jr. Foundation)

### Industrial Medicine

Rice, C. O. *Calculation of industrial disabilities of the extremities*. c1952. (gift of publisher)

### Infectious Diseases

Rantz, L. A. *The prevention of rheumatic fever*. c1952. (gift of publisher)

### Miscellaneous

Gillman, Joseph. *Perspectives in human malnutrition*. c1951. (gift of publisher)

Green, R. M. *A translation of Galen's hygiene*. c1951. (gift of publisher)

Mayer, C. A. *Fluid balance*. c1952. (gift of publisher)

### Neurology

Abramson, H. A., ed. *Problems of consciousness*. Transactions . . . 2nd conference, March 19/20, 1951. c1951. (gift of Josiah Macy, Jr. Foundation)

Mock, H. E. *Skull fractures and brain injuries*. c1950.

Ralli, E. P., ed. *Adrenal cortex*. Transactions . . . 2nd conference, November 16/17, 1950. c1951. (gift of Josiah Macy, Jr. Foundation)

### Nursing

Dakin, Florence. *Simplified nursing*. 5th ed. c1951. (from Nurses' Association)

Fash, Bernice. *Kinesiology in nursing: laboratory manual*. c1952. (from Nurses' Association)

Fisher, A. M. *Laboratory exercises and outlines in microbiology for nurses*. c1951. (from Nurses' Association)

Jamison, Sara. *Solutions and dosage*. 2nd ed. c1951. (from Nurses' Association)

### Ophthalmology

Sugar, H. S. *The glaucomas*. c1951. (gift of publisher)

### Orthopedics

American Academy of Orthopedic Surgeons. *Orthopaedic appliances atlas*. v.l. c1952.

Eve, Duncan. *Handbook on fractures*. c1947.

Greulich, W. W. *Radiographic atlas of skeletal development of the hand and wrist*. c1950.

Kendall, H. O. *Posture and pain*. c1952.

Lacroix, P. *The organization of bones*. 1951.

Mennell, James. *The science and art of joint manipulation*. 2nd ed. c1949.

Moseley, H. F. *Ruptures of the rotator cuff*. c1952. (gift of publisher)

Nangle, E. J. *Instruments and apparatus in orthopaedic surgery*. c1951.

Ragan, Charles, ed. *Connective tissues*. Transactions . . . 2nd conference, May 24/25, 1951. c1952. (gift of Josiah Macy, Jr. Foundation)

Smillie, I. S. *Injuries of the knee joint*. 2nd ed. c1951.

Snapper, I. *Medical clinics on bone diseases*. 2nd ed. rev. c1949.

Steindler, Arthur. *The traumatic deformities and disabilities of the upper extremity*. c1946.

#### Roentgenology

Pugh, D. G. *Roentgenologic diagnosis of diseases of bones*. 1951.

Schwartz, C. W. *The skull and brain roentgenologically considered*. c1951. (gift of publisher)

#### Therapeutics

Cash, J. E. *A textbook of medical conditions for physiotherapists*. 1951.

Kendall, H. O. *Muscles: testing and function*. c1949.

Krusen, F. H., ed. *Physical medicine and rehabilitation for the clinician*. c1951. (from Hawaii Chapter, American Physiotherapy Association)

Prosser, E. M. *Manual of massage and movements*. 1951.

#### Tuberculosis

Rich, A. R. *The pathogenesis of tuberculosis*. 2nd ed. c1951. (gift of publisher)

Willis, H. S. *Diagnostic and experimental methods in tuberculosis*. c1952. (gift of publisher)

#### Urology

Lippman, R. W. *Urine and the urinary sediment*. c1952. (gift of publisher)

Statistics which were compiled last month for our annual report, show that the Medical Library now comprises over 15,000 volumes. The Library has been growing at the rate of about 1,500 volumes a year, and takes its place among other good medium sized medical libraries.

We now have 935 registered borrowers, of whom 334 are doctors, 255 graduate nurses and 317 student nurses.

Our requests for research have increased tremendously, particularly telephone requests. As long as our small staff can handle the routine work and give busy doctors this extra service, we will continue to offer it. We want to remind our members again that they may call the Library (Ph. 65370), and ask that certain journals be set aside so that they will be ready for borrowing without delay.

## UMI MAKAHIKI I HALA\*

" . . . A number of recent publications have pretty clearly established the fact that intradermal vaccination with moderate doses [of typhoid vaccine] produces quite as much immunity as the more toxic subcutaneous vaccinations. . . . I am very sanguine about the ultimate outcome of this widespread intradermal inoculation in Hawaii."

E. A. FENNEL, M.D.

General Order No. 105, May 16, 1942, prohibits the use or operation of any electrical diathermy type machine after Sunday, May 17.

We are informed that regulations are being drawn up under which permission will be granted to operate these machines. In the meantime application blanks for such permission are available in the office of the Medical society.

**Dr. Arthur W. Duryea** announced the opening of offices in the Young Hotel Building recently.

**Dr. Samuel D. Allison**, Venereal Disease Control Officer for the Board of Health, recently went to the Big Island to discuss with the local administrative officers and physicians the frequency of venereal disease cases and methods of control.

**Dr. Marie Faus** spent May 1-18 on the island of Hawaii giving a course in home protection under the

auspices of the Adult Education Department of the University of Hawaii. Her classes were attended daily by at least 100 women.

**Dr. Leo Bernstein**, U. S. Public Health Service reserve, has taken up his duties as health officer for the county of Kauai.

**Dr. Edwin T. Kam** has been appointed government physician for the Kaneohe-Kaaawa district on the windward side of Oahu. **Dr. Clarence Chinn** is now government physician for the Kailua-Lanikai-Waimanalo district.

**Dr. T. L. Taylor** has resigned as superintendent of Waimano Home. **Dr. E. T. Ching** has been made Medical Director for that institution.

**The Martin Lichters** added a third child to their family on March 22—a daughter, Linda M.

**Dr. Kusunoki** has recovered lately from an attack of kidney stones. He made a trip recently to Honolulu to observe the operation of the immunization program on Oahu preparatory to such a program being undertaken on the Island of Maui.

There will be three in the family of **Dr. John Sanders** some time in July.

There is a new arrival at Honolulu Plantation — **Dr. T. P. Chou**, formerly the head of the E. E. N. T. department in the Red Cross Hospital at Shanghai. Dr. Chou was educated in England and at Yale.

\* Ten years ago. From Volume 1, Number 5, May-June, 1942.



# BOOK REVIEWS

## The Internship.

By Roscoe L. Pullen, A.B., M.D., F.A.C.P., 34 pp., Price \$1.25, Charles C. Thomas, 1952.

This monograph edited by Dr. Pullen is another in a series of "American Lectures in Internal Medicine". It is of attractive size and arrangement, states clearly the deficiencies of present-day internship programs, and gives objective consideration to development and re-definition of the internship and its present place in medical education. Certainly there would be wide differences of opinion among the readers concerning the purposes of internship, but it is apparent to all that the problem must soon be brought out in the open and proper consideration of its future place in education more adequately defined.

Again we may disagree with statistics mentioned, such as in patient's stay, etc. All things considered, however, Dr. Pullen presents his interpretation of a difficult subject and his recommendations step by step clearly and concisely.

It is interesting reading and will without doubt provide an abundance of discussion material among the medical profession, thereby accomplishing its intended purpose.

JOHN L. MORIARTY

## Cardiac Pain.

By Seymour H. Rinzler, M.D., F.A.C.P., 151 pp. with 13 illustrations, Price \$3.75, Charles C. Thomas, 1951.

The next time you make a diagnosis of angina pectoris, go to the library and read this book.

It seems to me that it has three good qualities: (1) Illuminating historical notes on clinical and therapeutic concepts of cardiac pain; (2) Strong emphasis on the subject of the necessity of evaluating drugs in relieving angina pectoris; (3) Brevity.

Despite the title, one of the interesting parts of the book is a discussion of painless myocardial infarction. This is an excellent little book.

ALFRED S. HARTWELL, M.D.

## Hemodynamics in Failure of the Circulation.

By W. B. Youmans, M.D., Ph.D. and A. R. Huckins, M.S., M.D., 80 pp. with 10 illustrations, Price \$2.75, Charles C. Thomas, 1951.

This monograph reviews clearly the basic principles of the hemodynamics of circulation. Many of the viewpoints on the failure of the circulation have undergone changes in recent years due to new investigative methods available. The viewpoint presented by the authors of this book is one of the so-called "Forward Failure" theory. The relationship between the cardiac output of the heart and the ensuing role of the kidney in the regulation of blood volume is well presented.

This is an excellent summary for those interested in this field.

KIKUO KURAMOTO, M.D.

## Hypertension.

By Irvine H. Page, M.D., 90 pp., Price \$3.00, 6th Edition, Charles C. Thomas, 1951.

What to tell the patient about high blood pressure is answered in this book. Dr. Page is Director of the Research Division of the Cleveland Clinic Foundation, Cleveland, Ohio. His own investigations on hypertension have been numerous and his clinical experience extensive. His manual, therefore, is authoritative.

In simple language, he tells the patient: (1) what high blood pressure is; (2) what can be done to relieve it (to a certain degree); and (3) how the hypertensive can live comfortably. This means that he adopts a middle-of-the-road attitude toward medical and surgical therapy and toward the ever-controversial diet therapy. Mention of new experimental drugs, DHO (dihydroergocornine), hydrazino-phthalazine, and hexamethonium, would perhaps better have been left out of this patient's manual until the doctors themselves had more chance to read about them in the current clinical literature.

S. E. DOOLITTLE, M.D.

## Perspectives in Human Malnutrition.

By Joseph Gillman, D.Sc., M.B., B.Ch., and Theodore Gillman, M.Sc., M.B., B.Ch., 554 pp. Price \$18.00, Grune & Stratton, Inc., 381 Fourth Avenue, New York, 1951.

This is a comprehensive work setting forth the theories of the authors on the effects of malnutrition upon body processes and specific organs resulting from their extended clinical and laboratory observations of large numbers of African pellagrins.

The authors deplore the oversimplification of the etiology of nutritional disease. They do not accept the theory that pellagra is the result of a specific vitamin deficiency, but believe, rather, that it is an over-all imbalance of the diet.

In many well documented, splendidly illustrated chapters the authors present the diverse clinical and pathological manifestations of malnutrition in their patients. In addition to six detailed chapters on the skin, there are chapters on the oral cavity, salivary glands, tongue, stomach, small and large intestine, and the pancreas. Six chapters are devoted to the liver in severe malnutrition.

As scientific workers for many years at the University of Witwatersrand, Johannesburg, South Africa, the authors should speak with authority when they suggest general improvement of the diet, especially of pregnant mothers and children, rather than the addition of a few specific nutrients, as the best solution for the serious problem of malnutrition in the Africans.

Physicians will find this an excellent reference book. Contents are clearly indicated under each chapter heading at the beginning of the book, as well as in a good index. There is a detailed bibliography, 259 illustrations and 45 tables and charts.

CAREY D. MILLER, M.S.

### **The Pathogenesis of Tuberculosis.**

By Arnold R. Rich, M.D., Second Edition, 1018 pp. with 105 illustrations, Price \$15.00, Charles C. Thomas, 1952.

Despite the voluminous literature on tuberculosis, it is only at very rare intervals that there appears a "classic". Worthy of such designation and deserving of a place on that all too small shelf of "immortal" writings on tuberculosis is Dr. Arnold Rich's masterly survey of our present knowledge of the fundamental principles of this disease. Usually a medical work attaining the rank of "classic" does so either because it constitutes an original contribution of signal merit or because it presents a broad survey of knowledge of a particular field in an outstanding manner. Dr. Rich's book rates high on both counts. His many years of experience in the laboratory and autopsy room eminently qualify him for the stupendous task of setting forth "the basic factors and principles which influence the occurrence of tuberculous infection or determine its progress or arrest." No previous survey, to my knowledge, has been as wide in scope, since it deals fully not only with all aspects of the tubercle bacillus, but with the multifold and complex factors of native and acquired resistance and their relationships with lesions and symptoms. Dr. Rich's well known brilliant studies in the field of hypersensitivity and resistance in disease have revolutionized our ideas and now constitute the underlying concepts upon which are based our present theories of the pathogenesis of tuberculosis.

This second edition brings the work up to date by the addition of new material based upon the contents of seventy-four additional references, bringing the bibliography up to a total of 1,500. That the book reflects the author's preferences and poses theories not generally accepted does not in any way detract from its immense value. It is a most stimulating and readable book, absolutely indispensable to pathologists and clinicians alike.

H. H. WALKER, M.D.

### **Cellular Changes with Age.**

By Warren Andrew, Ph.D., M.D., 74 pp. Price \$2.50. Charles C. Thomas, 1952.

Why do organisms grow old and die? This little monograph is packed with thought-provoking ideas on this subject. It is scientific to the highest degree, yet it is very readable and is quite convincing in proving the hypothesis that in the last analysis according to any theory, senescence is due to protoplasmic changes, changes which occur in individual cells.

The implications of this book are in no way so elusive or difficult of vision as the small elements on which its conclusions are based. It provokes thought on such questions as why once lovely skin becomes thin, wrinkled, and even repulsive in the twilight of life.

In concluding this book, the author touches on the basic philosophy in which we are all interested, namely, the search for a longer, happier and more productive life for human beings. He concludes with this statement: "... the study of the normal aging process must eventually illumine the dark caverns of our present ignorance."

This book should be of interest to all scientists dealing with living organisms, both plant and animal. It will be of special interest to physicians and nurses concerned with geriatric problems.

WALTER B. QUISENBERRY, M.D.

### **The Calculation of Industrial Disabilities of the Extremities.**

By Carl O. Rice, M.D., Ph.D., 284 pp. with 204 illustrations, Price \$10.50, Charles C. Thomas, 1952.

The problem of arriving quickly at a just evaluation of an industrial disability is often not easy. The author here makes an excellent attempt to simplify the process so that the attending physician may calculate a disability with a high degree of precision.

To accomplish his purpose, the author has enclosed numerous excellent illustrations from which can be read off the percentage of disability. These illustrations give the physician an opportunity to quickly determine the percentage of disability present.

This book is of good quality and for the subject covered it is not difficult to read. The process of evaluating a disability as described here is original with this author.

This book should have its greatest appeal to all physicians who do industrial work and would like a book that simplifies the complex mechanism of disability evaluation.

B. ALLEN RICHARDSON, M.D.

### **The Prevention of Rheumatic Fever.**

By Lowell A. Rantz, M.D., 66 pp., Price \$2.25, Charles C. Thomas, 1952.

This book is a good concise review of the relationship of the hemolytic streptococcus to rheumatic fever and should be read by everyone who has patients with either active or inactive rheumatic heart disease, or rheumatic fever, under his care.

On Page 5 is found a sentence which sets the tone of the book: "Most investigators have accepted the casual relationship between infection by hemolytic streptococci and rheumatic fever, and have applied this information successfully in the prevention of this disorder." There seems to be overwhelming evidence that prevention of streptococcus infection in patients who have previously had rheumatic fever will prevent a reactivation of the disease.

It should be emphasized that the step or steps between streptococcus infection and the development of rheumatic fever are not as yet known. They probably lie in the field of biochemistry and may be elucidated in the next decade or so.

There is considerable information in this little book on the evaluation of antibiotics in the prevention of rheumatic fever.

ALFRED S. HARTWELL, M.D.

### **Surgical Measures in Hypertension.**

By Reginald H. Smithwick, M.D., 95 pp., Price \$3.00, Charles C. Thomas, 1951.

This informative monograph starts off with a short historical and physiological review on the subject of hypertension in man. In the main it describes surgical measures employed in this condition and presents the author's experience with sympathectomy and splanchnicectomy. Illustrations of operative technic are given. Indications for limited operative procedures are well discussed. Postoperative results are summarized.

Format and printing are excellent and there is a good bibliography. This monograph should be read by all internists and surgeons interested in the subject.

SAMUEL L. YEE, M.D.



### The Merck Index.

Sixth Edition, 1,167 pp. Price \$8.00. Merck and Co., Inc., 1952.

This book, long ago established as an outstanding chemical encyclopedia, needs no introduction or explanation. However, the sixth edition, which has just been released, is worthy of attention.

The list of drugs and chemicals is up-to-the-minute including information about the antibiotics as well as drugs released as recently as the latter part of 1951. Thousands of drugs have been added to this edition thereby greatly increasing the scope of the book.

The appendix has been completely revised. A large section is now devoted to organic chemical reactions listed by the name of the reaction. Radioactive isotopes are listed, including those used in medicine. The final pages deal extensively with first aid in poisoning.

I feel that *The Merck Index* is as valuable to the physician, chemist, and pharmacist as the stethoscope, test-tube, and mortar.

MISS JOY E. COCHRAN  
(Associated with Clinton D. Summers)

### Electrocardiographic Studies in Normal Infants and Children.

By Robert F. Ziegler, M.D., 207 pp., Price \$10.50, Charles C. Thomas, 1951.

Many advances have been made in the field of electrocardiography in the past decade. During the past several years unipolar leads have contributed tremendously to the basic understanding of this science. Unfortunately, electrocardiographic studies in infants and children have not kept pace with the progress noted in adult studies. Normal standards have been sadly inadequate, especially in regards to unipolar leads. In this book the author has made a very comprehensive study of unipolar extremity and precordial leads on 635 subjects ranging in age from 15 minutes to 16 years. The appendix serves as an excellent reference for pediatricians and cardiologists since it contains all of the pertinent statistical data in the author's study.

ALBERT H. ISHII, M.D.

### Urine and the Urinary Sediment.

By Richard W. Lippman, M.D., 128 pp. with 62 illustrations, Price \$7.50, Charles C. Thomas, 1952.

This volume is described on the frontispiece as a practical manual and atlas on urine and the urinary sediment, and it lives up to this representation. In a clear and concise manner, constituents of the urine, abnormalities of these constituents, and their significance are all discussed. In a separate section, divorced from these considerations, there is a description of technics.

The organization of the book allows one to follow his particular interest without being burdened by material which he might not feel to be pertinent.

The mechanical make-up of the book is excellent. The print is large and the spacing is such that reading is easy. The work has a small but adequate index. There are numerous illustrations, mostly in color, and tables are used to advantage.

This is a book which would be of value to any physician dealing with renal disease or doing laboratory examinations on the urine.

W. HAROLD CIVIN, M.D.

### Management of the Newborn.

By Arthur Hawley Parmelee, M.D., 358 pp. Price \$7.00. Year Book Publishers, 1952.

Based on his extensive experience and the medical writings of his own and others, Dr. Parmelee's book presents the subject in an interesting style. There are many "pearls" in this book that all who manage new born infants could profitably collect for clinical application. Certain controversial aspects are very well handled. This is one of the most practical books I have read on the subject in recent years.

C. K. KOBAYASHI, M.D.

### Also Received

#### Neurosurgery: An Historical Sketch.

By Gilbert Horrax, M.D., Sc.D., 135 pp. with 69 illustrations. Price \$3.75. Charles C. Thomas, 1952.

#### Rupture of the Rotator Cuff.

By H. F. Moseley, M.A., D.M., M.Ch. (Oxon), F.R.C.S., F.A.C.S., 96 pp. with 108 illustrations. Price \$6.50. Charles C. Thomas, 1952.

#### Diagnosis and Experimental Methods in Tuberculosis.

By Henry Stuart Willis, M.D. and Martin Marc Cummings, M.D., 2nd edition, 373 pp. Price \$10.00. Charles C. Thomas, 1952.

#### A Translation of Galen's Hygiene.

By Robert Montraville Green, M.D., 272 pp. Price \$5.75. Charles C. Thomas, 1951.

#### Visceral Innervation and its Relation to Personality.

By Albert Kuntz, Ph.D., M.D., 152 pp. Price \$4.50. Charles C. Thomas, 1951.

#### Formulary and Therapeutic Guide.

355 pp. Price \$3.00. Appleton-Century-Crofts, Inc., 1951.

#### Nutrition and Climatic Stress.

By Marjorie Edman and H. H. Mitchell, 244 pp. with 8 illustrations. Price \$6.75. Charles C. Thomas, 1952.

#### Bulletin of the Hospital for Joint Diseases.

Vol. 12, No. 2, October, 1951, Henry L. Jaffe Anniversary Volume. Price \$6.00. Waverly Press, Inc., 1951.

#### PDR—Physicians' Desk Reference to Pharmaceutical Specialties and Biologicals.

1952, Sixth Edition. Medical Economics, Inc., 1951.

#### Surgical Clinics of North America.

December 1951, Philadelphia Number, 1,916 pp. with 554 figs., Three-Year Cumulative Index (1949, 1950, 1951), \$18.00 per clinic year, cloth bound; \$15.00 per clinic year, paper bound. W. B. Saunders Company, 1951.

#### Surgical Clinics of North America.

February 1952, Chicago Number, pp. 1 to 344 incl., figs. 1 to 140 incl., \$18.00 per clinic year, cloth binding; \$15.00 per clinic year, paper binding. W. B. Saunders Company, 1952.

#### Medical Clinics of North America.

January 1952, Chicago Number, pp. 1 to 301 incl., figs. 1 to 28 incl., \$18.00 per clinic year cloth binding; \$15.00 per clinic year paper binding. W. B. Saunders Company, 1952.

#### Medical Clinics of North America.

March 1952, Tulane/Toronto Number, pp. 303 to 600 incl., figs. 29 to 35 incl., \$18.00 per clinic year cloth binding; \$15.00 per clinic year paper binding. W. B. Saunders Company, 1952.

# COUNTY SOCIETY REPORTS

## MAUI COUNTY MEDICAL SOCIETY

A regular meeting of the Maui County Medical Society was held at the Maui Grand Hotel on January 15, 1952 with Dr. E. Shimokawa presiding.

Members present were: Drs. E. Shimokawa, K. Izumi, Wm. Patterson, R. Cole, J. A. Burden, J. Sanders, Wm. Toney, F. St. Sure, E. B. Underwood, H. Kushi, T. W. Kanda, T. G. Lathrop, J. F. Fleming and A. Y. Wong. Guests present were: Dr. Robert Faus, Mr. J. R. Veltman, Mrs. Peter James of Hawaii Medical Service Association.

Dr. Lathrop mentioned that the Cancer Society is taking advantage of a training program for cytologic laboratory work for three months under Dr. Traut in San Francisco. Publicity is being given to get applicants by way of radio and newspaper. He reminded that T.B. posters are being distributed to M.D.'s offices and also would like to have T.B. pamphlets disseminated to patients through M.D.'s offices.

He remarked that only birth, death, and fetal death certificates will be distributed to doctors' offices and they should be sent to him as registrar. Transfer permit within the island of Maui is now not necessary. He concluded that there seems to be some confusion as to cause of death in the death certificate. Underlying cause should be listed as that leading to the cause of death.

A communication was read in regard to setting up a territorial committee to arouse interest and secure participation in an important and worthwhile enterprise, that of the American Medical Education Foundation of the American Medical Association, inasmuch as the response for contributions has been very poor. It was moved by Dr. Sanders and seconded by Dr. Underwood that Dr. McArthur be the Maui member to this committee. Motion passed unanimously.

It was moved by Dr. Underwood and seconded by Dr. Burden that the By-laws be changed to read that two names be submitted for each elective office. Motion tabled for one month.

Mr. Veltman and Dr. Faus talked on HMSA.

A special meeting of the Maui County Medical Society was held at the Maui Grand Hotel on February 14, 1952 with the President, Dr. E. Shimokawa, presiding. Members present were: Drs. H. Kushi, Wm. Patterson, J. A. Burden, R. Cole, J. Ferkany, T. G. Lathrop, R. J. McArthur, Wm. Toney, E. Shimokawa, J. Fleming, T. W. Kanda, E. B. Underwood, J. Sanders, F. St. Sure, L. S. Rockett, K. Izumi, S. Ohata and A. Y. Wong. Guests were Dr. V. Boido and Dr. H. Arnold, Jr.

Dr. Arnold, Jr. briefly discussed A.M.A. membership. He talked on an excellent annual review of the highlights of medical progress during the past year, "Medicine of the Year". The proposed volume will be a bound issue of eighty pages and will sell for \$2.00 per copy. A show of hands revealed unanimous approval to purchase it. Dr. Arnold then spoke on "Dermatoses of the Hand".

Dr. Cole reported on H.M.S.A. He mentioned that H.M.S.A. is striving to have a 1% withholding instead of the present 10%. However, this has to have the approval of the counties. He added that care should be

exercised to cut down on office calls. Dr. Toney moved, seconded by Dr. Fleming, that the Maui County Medical Society give a vote of confidence to H.M.S.A. and continue to give H.M.S.A. the same cooperation it has given in the past. Motion carried unanimously.

Dr. Lathrop reminded the M.D.'s that in filling out registrations of birth, forty weeks is the full term gestation and that no birth certificate with erasures will be accepted. On behalf of the local Polio Chapter, he extended an invitation to attend the Nursing Care Institute on Poliomyelitis on February 29, 1952.

Amendment carried over from last meeting whereby two names be submitted for each elective office was brought up. After some discussion, the amendment was not passed, four voting in favor and ten against it.

Dr. Lathrop's membership to the Society was next on the agenda. Board of Governors approved the application. All members voted in favor of accepting Dr. Lathrop into our Society.

A. Y. WONG, M.D.  
*Secretary, pro tem.*

The regular meeting of the Maui County Medical Society was held at the Maui Grand Hotel on March 11, 1952 with Dr. Edward Shimokawa presiding. Present were Drs. Izumi, Cole, Burden, Underwood, Toney, Sanders, Ferkany, Tompkins, Patterson, Shimokawa, McArthur, Lathrop, Kanda, Wong and Ohata.

Guest speaker, Dr. Richard S. Dodge, gave a very interesting talk on congenital deformities of the hip.

The question as to "What constitutes permission to get blood from intoxicated persons" was brought up by Dr. Lathrop. He read a letter from Nathaniel Felzer, Deputy City and County Attorney from Honolulu, who stated that the permission may be in oral or written form, expressed or implied, and he also stated that it depends on the circumstance. It would be considered a better practice to tell the patient that the evidence obtained may be used against him although this is not absolutely necessary. The question is still pending further clarification.

The president read the following communications:

1. From Dr. Waite, who advised the Medical Society that Dr. Walter A. Fansler, professor of surgery (colon and rectal surgery), University of Minnesota, School of Medicine, will be on Maui from March 3 to 25, 1952 at Hotel Hana-Maui and that he will be available as a speaker if the group is interested.

2. From Mrs. Edith C. Bennett, who invited the members of the Society to take part in the fifth annual congress on Obstetrics and Gynecology in Cincinnati, Ohio, from March 31 to April 4, 1952.

3. A copy of the letter from Dr. Kenneth Fowler to Dr. Frank St. Sure was read for the information of the group.

4. Letter from Dr. Ed Kushi, who declined nomination for presidency, was presented.

Dr. Cole, chairman of the nominating committee presented the following slate:

President.....DR. J. A. BURDEN  
Vice-President.....DR. HAROLD S. KUSHI  
Secretary-Treasurer.....DR. EDMUND TOMPKINS

Dr. McArthur moved that nominations be closed; motion seconded by Dr. Ferkany and passed unanimously.

Delegates, Dr. Wm. Toney and Dr. Wilkinson were



elected to the Territorial Medical meeting and were accepted unanimously.

Dr. Cole was elected as delegate to the Executive Board of H.M.S.A. with Dr. Lathrop as alternate. Delegates were approved unanimously.

SEIYA OHATA, M.D.  
*Secretary, pro tem.*

A special meeting of the Maui County Medical Society was held at the Wailuku Hotel on March 26, 1952, with President, Dr. J. A. Burden, presiding.

Dr. Walter Fansler, Professor of Surgery, University of Minnesota, was the guest speaker, and his topic was "Simple Proctology Procedures Most Commonly Seen by the Practitioner." He gave a very interesting discussion on rectal surgery pertaining to anal stenosis, anal fissures, hemorrhoids, fistulas, rectal abscesses and pruritis ani.

Dr. R. B. Cloward offered to speak at one of our meetings, on his surgical treatment of low back pain, and the secretary was instructed to contact Dr. Cloward, asking him if he could postpone speaking to the Medical Society until a later date as our program is filled at the present time.

EDMUND TOMPKINS, M.D.  
*Secretary-Treasurer*

## HAWAII COUNTY MEDICAL SOCIETY

The 318th regular meeting (annual meeting) of the Hawaii County Medical Society was called to order by President T. David Woo at 9:00 p.m. (following a dinner) on Saturday, March 29, 1952 at the Hilo Country Club with the following members present: Drs. Carter, M. H. Chang, Crawford, Fernandez, Haraguchi, Hata, Hayashi, Kasamoto, Kutsunai, Leslie, Loo, Miyamoto, Mizuire, Okumoto, Orenstein, Ota, Tomoguchi, Francis Wong, Woo, Yamanoha, Yuen, Steuermann and Kaufmann. Guest was Dr. Harry L. Arnold, Jr., President of the Territorial Medical Association.

Dr. S. Kasamoto then brought up the question of the Medical Indigent Program. He stated that it has been planned that a token fee of \$50.00 be given the surgeon and \$10.00 for the assistant when called in to do surgery on indigent patients. He further stated that a token fee of \$10.00 should be given to the doctor who assists a government physician. Following a short discussion it was moved by Dr. A. Orenstein, seconded by Dr. W. Loo, that the Society go on record as approving such a plan. The motion was carried unanimously.

Dr. Crawford reported on the activities of the Disaster Council.

Dr. W. Loo reported on the activities of the Library Committee. He recommended that \$650.00 be granted to the Library Committee to carry on its function during the forthcoming year. Dr. A. Orenstein moved that the Library Committee function on a "pay as you go basis" instead of granting a lump sum as recommended by the Chairman of the Library Committee. Motion was seconded by Dr. T. David Woo and passed unanimously.

The Nominating Committee reported the following Nominees as Officers of the Society for the coming year.

President.....	DR. S. KASAMOTO
Vice-President.....	DR. C. HAYASHI
Secretary.....	DR. R. YAMANOKA
Treasurer.....	DR. KAY OTA
Censor.....	DR. JOHN JENKIN

Dr. C. Carter then moved, seconded by Dr. W. Loo, that the nominations be closed and that the Society accept the Nominating Committee's slate of Officers and instruct the Secretary to cast a unanimous vote for the entire slate. Motion was carried unanimously.

Dr. S. Kasamoto then took over the Presidency. The Society gave a vote of thanks to the outgoing officers.

Dr. Harry Arnold, President of the Territorial Medical Association, spoke on the AMA and its activities and the Workmen's Compensation Fee Schedule.

Following the business portion of the meeting, games and entertainment were held. Numerous prizes were given to the winners. A golf tournament was also held earlier in the afternoon (prior to the dinner meeting).

FRANCIS F. C. WONG, M.D.  
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital on Feb. 13, 1952 at 7:45 p.m. with Dr. K. Fujii presiding. Those present were Drs. Fujii, Kim, Kuhlman, Wade, Goodhue, Masunaga, Cockett and Ishii.

A letter from Dr. Maxwell D. Boyd pertaining to examination of inductees was read. The letter requested that we reconsider our last action on the subject and rediscuss the matter. It was moved by Dr. Wade and seconded by Dr. Goodhue that there was no need for rediscussion and leave it in status quo. It was unanimously carried.

Dr. Kuhlman brought up the subject of the Diabetic Kit—the showing of films and teaching program, a 6 weeks' training period on diabetes for the public. The cooperation of the Society was urged and it was suggested that at least one physician attend these programs. Dr. Wade moved that we go on record as approving this important program. Dr. Goodhue seconded and it was unanimously accepted.

Dr. Peter Kim on behalf of the Board of Health spoke on the problem of venereal diseases, the increasing rate and the difficulty encountered in pursuing contacts. Description of contacts and other necessary information were requested from physicians.

On immunization, Dr. Kim stated that the Board of Health recommended tetanus and typhoid injections for students entering high school.

The Disaster and Educational Committee of the Nurses' Association, County of Kauai, is sponsoring a public meeting on Civil Defense. Two days in early March have been tentatively selected for this endeavor. All physicians are urged to attend and lectures by them will be highly appreciated.

The Civil Defense meeting recently held in Honolulu was attended by Drs. Kim and Cockett from Kauai. Medical plans for the outside islands were emphasized.

Dr. Fujii informed the members that Dr. Vasconcellos will be very happy to help us organize our own chapter of the American Academy of General Practice in the event such a move is thought desirable by the active members of the Academy.

The majority of the members agreed to change the regular Society meeting date from the 2nd Wednesday to the 2nd Tuesday of each month. In order to comply with the By-Laws, Dr. Goodhue suggested that the secretary communicate with Mrs. Bennett regarding the procedure necessary in doing so.

The regular monthly meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital on March 12, 1952 at 7:30 p.m. with Dr. K. Fujii presiding. Those present were: Drs. Cockett, Kuhns, Boyden, Kuhlman, Kim, Masunaga, Goodhue, Wallis, Fujii, Wade and Ishii.

Dr. Peter Kim spoke on the Tuberculosis Case Finding Program introduced by the T.B. and Health Association in conjunction with the Territorial Board of Health. He sought the members' opinion, suggestion, and possible solution regarding positive Mantoux findings in high school students—9th-12th grades in three of the high schools. Chest x-rays were recommended for the positive students and the respective plantation physicians were asked whether it would be at all feasible to make these studies for those under their medical jurisdiction. It was suggested that the T.B. and Health Association supply the films and each plantation will do the roentgenological work.

Dr. Dorian Paskowitz, head of the Territorial Bureau of Venereal Disease and Cancer Control, spoke of community-wide action program, better planning and cooperation between the police and the Board of Health, improvement in the area of courts and prosecution and the need for improved contact investigation, in regard to venereal diseases.

Election of officers for the year 1952-1953 followed.

President.....	DR. MARVIN BRENNCKE
Vice-President.....	DR. CLYDE H. ISHII
Secretary-Treasurer.....	DR. PETER KIM
Delegate.....	DR. SAM WALLIS
Alternate Delegate.....	DR. JAY KUHN
Board of Censors.....	DR. K. FUJII
	DR. SAM WALLIS
	DR. JAY KUHN

The proposed amendment to the Constitution and By-Laws, Article IX of the By-Laws. The announcement is made as follows: In accord with Article IX of our Constitution & By-Laws, the following amendment is proposed to take effect immediately after adoption.

Amendment No. 1, Article IX, Section 1 of the Constitution be changed to read Tuesday.

Voting on this amendment will take place at the next monthly meeting.

CLYDE H. ISHII, M.D.  
Secretary

The regular monthly meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital Wednesday, April 9, 1952, at 7:30 p.m., with Dr. Ishii calling the meeting to order due to the delay in arrival of the President, Dr. Brennecke, who presided after the minutes were read. Members present were Drs. Cockett, Wade, Goodhue, Boyden, Fujii, Ishii, Masunaga, Wallis, Brennecke, and P. Kim. Guests were Drs. Arnold, Jr., Robert Faus, and Baumgarten.

Change of Regular Meeting Date: The proposed amendment to Article II, Section 1, relating to the change in the Regular Meeting day from Wednesday to Tuesday having been duly announced in writing at the previous meeting in accordance with Article IX of the By-Laws, Dr. Goodhue moved, seconded by Dr. Cockett, that the said Article II, Section 1, be amended by substituting the word "Tuesday" for "Wednesday." The motion was passed by all members present.

Physician for First Aid Station in the coming County Fair: The President appointed Dr. Ishii to the post.

There being no further business the meeting was

turned over to the guest speakers of the evening. Dr. Harry Arnold, Jr., in the annual presidential address, spoke on (1) A.M.A. membership in Hawaii with comments on the study made on those not contributing, (2) the new Industrial Accident Fee Schedule, (3) the A.M.A. Medical Education Foundation program, (4) the coming 62nd Annual Meeting of the Hawaii Territorial Medical Association, and (5) the resignation of Miss Eyman of Mabel Smyth Building staff.

The following discussions were mainly on the matter of the Fee Schedule. Majority of the members were of the opinion that such a schedule should be adopted on Territorial-wide basis. It was moved and duly seconded that the Delegate to the Territorial Medical Convention be authorized to state that the members of the Kauai County Medical Society recommend the adoption of the new Industrial Accident Fee Schedule of the Honolulu County Medical Society on a Territorial-wide basis. The motion was passed unanimously.

The next guest speaker was Dr. Faus, Medical Director of the H.M.S.A. He discussed (1) the current status of the H.M.S.A., (2) proposed negotiation of a contract between the County Medical Society and H.M.S.A., (3) the proposed negotiation of a contract between the individual physician and H.M.S.A. on Administrative Operating Procedures for participating physicians of H.M.S.A., and (4) the proposed change in the income clause setting the income limit of H.M.S.A. members from 3,000 to 3,600 and 4,000 to 4,800 as related to the new Fee Schedule soon to be out.

It was moved, seconded, and voted unanimously that the President and Secretary be authorized to sign the Agreement between the H.M.S.A. and the Kauai County Medical Society. Dr. Faus then requested that names of all physicians wishing to participate be submitted to him at a later date.

On the matter of changing the income clause, Dr. Wallis moved, seconded by Dr. Fujii, that the proposed change be accepted by the members. After a brief discussion, Dr. Wade motioned and seconded by Dr. Cockett to lay the income clause motion on the table. The motion was passed by a vote of 4 to 2.

Dr. Elden C. Baumgarten, surgeon from Detroit, Michigan, spoke a few words on various voluntary health plans existing in his State. He stressed the catastrophic feature of the plans, and he preferred to call these health plans "social movements" rather than insurance plans. It was also his belief that the American people did not, and should not be taught to, expect a total health service plan.

PETER KIM, M.D.  
Secretary

## HONOLULU COUNTY MEDICAL SOCIETY

On behalf of the Society, the Board of Governors welcomed Drs. Y. T. Wong and Robert S. Mookini, Jr. to regular membership. New associates are Dr. Thad W. Penn and Col. Charles H. Gingles.

The March Meeting of the Society was held March 7, 1952 in the Mabel Smyth Auditorium. Dr. John William Devereux presided with approximately 130 members and guests present.

The Hawaii Chapter of the American College of Physicians presented a program entitled, "The Patient with Jaundice." Dr. Nils P. Larsen, Chairman, introduced the subject.



1. Dr. John Bell gave the history, racial and geographic distribution, story of epidemics, findings of the local blood bank in regard to occurrences following blood transfusions.
2. Dr. S. E. Doolittle discussed "The Differential Diagnosis."
3. Lt. Col. Otto A. Wurl gave an illustrative presentation of "gross and microscopic pathology" of cases associated with jaundice.
4. Dr. Frederick L. Giles presented the "Treatment of Jaundice."

An open forum was then held for comments and questions.

The following resolution in memory of Dr. Robert A. Kimura was unanimously approved by the membership.

**WHEREAS, Dr. Robert Akia Kimura was a conscientious practitioner of general medicine and surgery in Honolulu from 1929 to 1952, and during this period gained the confidence of his many patients; and**

**WHEREAS, he was a member of the Honolulu County Medical Society and the Hawaii Territorial Medical Association since March 7, 1930; and**

**WHEREAS, Dr. Robert Akia Kimura died after a brief illness on January 31, 1952; now therefore**

**BE IT RESOLVED, that the members of the Honolulu County Medical Society do hereby express their sincerely felt sense of loss at his untimely demise; and be it further**

**RESOLVED, that a copy of this resolution be spread upon the minutes of the Society, and be it further**

**RESOLVED, that a copy of this resolution be sent to Mrs. Fusaka Kimura and sons, Chris, Herbert and Stanley.**

The *Agreement for Participating Physicians and the Administrative Operating Procedure for Participating Physicians* were circulated to all regular members of the Society. A lengthy pro and con discussion followed on whether or not the Society wanted to enter into a formal participating contract with the Hawaii Medical Service Association.

Dr. Faus stated that the main objective of the contract was to make the HMSA service plan salesworthy, for HMSA in order to render their services must have a contract with the dispensers of the service. Dr. Devereux stated that non-participating physicians will be treated in the same manner as participating physicians, except in the matter of grievances, in which case they will have no recourse.

After further discussion the following motions were presented:

**Dr. Chay moved that the Administrative Operating Procedure for Participating Physicians of the HMSA and the Agreement for Participating Physicians be approved as circulated. This motion was duly seconded and by a show of hands carried.**

**Dr. Palma moved to empower the Officers of the Honolulu County Medical Society to sign the contract binding the Medical Society with the HMSA. Said contract to take effect on April 1, 1952. Upon receiving a second, this motion by a show of hands, carried almost unanimously.**

WILLIAM S. ITO, M.D.  
Secretary

The annual meeting of the Honolulu County Medical Society and the Library was held on April 4, 1952 at 7:30 p.m., in the Mabel Smyth Auditorium, with Dr. John William Devereux presiding; approximately 75 members and guests present.

### *Report of the Officers and Committee Chairmen:*

The following reports were presented and accepted. It was recommended that the Committee on Forms of Medical Practice investigate the recent survey prepared by the I.L.W.U. on their proposed form of contract medical practice.

Secretary's Report.....	Dr. William S. Ito
Treasurer and Budget Committee Report.....	Dr. C. M. Burgess
Program Committee Report.....	Dr. R. C. Durant
Committee on Forms of Medical Practice.....	Dr. H. E. Bowles
Fee Adjustment Committee Report.....	Dr. T. S. Richert
Public Service Committee Report.....	Dr. I. Kawasaki
Postgraduate Committee Report.....	Dr. V. C. Waite
Grievance Committee Report.....	Dr. E. K. Chung-Hoon
HMSA Representatives Report.....	Dr. Lyle G. Phillips
Preparedness Committee Report.....	Dr. Robert Faus
Report of the Library Board of Governors.....	Dr. Wm. M. Walsh
Library Committee Report.....	Dr. I. Kawasaki
Woman's Auxiliary Report.....	Mrs. Douglas Bell
President's Address.....	Dr. John Wm. Devereux

These reports are on file in the Medical Society office.

### *Election of Officers:*

Dr. John M. Felix, Chairman of the Nominating Committee, read the report of his committee and the President presented the names for the various offices. Adequate opportunity was given for nominations from the floor. The Secretary was instructed to cast a unanimous ballot for those positions for which there was no competition.

Election was by written ballot with Drs. John M. Felix, Robert Bailey, H. Q. Pang and W. Quisenberry appointed as tellers. The following were elected:

#### *Officers:*

DR. WM. M. WALSH—President  
DR. WM. S. ITO—Vice-President  
DR. C. M. BURGESS—Secretary  
DR. R. C. DURANT—Treasurer

#### *Board of Governors (for two years)*

DR. JOHN BELL  
DR. T. ALAN CASEY  
DR. E. K. CHUNG-HOON  
DR. HOMER IZUMI

#### *Alternate Governors (for one year)*

DR. ROBERT KATSUKI  
DR. CLIFFORD KOBAYASHI  
DR. VERNE C. WAITE

#### *Board of Censors (for three years)*

DR. SAMUEL L. YEE

#### *Committee on Forms of Medical Practice (for five years)*

DR. JOHN WM. DEVEREUX

#### *Delegates to the Hawaii Territorial Medical Association (for two years)*

DR. RICHARD S. DODGE  
DR. JOHN M. FELIX  
DR. GILBERT C. FREEMAN  
DR. TAKEO FUJII  
DR. JOSEPH LAM  
DR. A. L. VASCONCELLOS  
DR. RODNEY WEST

#### *Alternate Delegates to the Hawaii Territorial Medical Association (for two years)*

DR. DONALD DEPP  
DR. RAYMOND DUSENDSCHON  
DR. WALTER CHUNG  
DR. C. C. MCCORRISTON  
DR. FRANCIS T. KANESHIRO  
DR. MASATO MITSUDA  
DR. JAMES T. S. WONG

#### *Representatives to the Hawaii Medical Service Association (for two years)*

DR. EDWARD F. CUSHNIE  
DR. H. Q. PANG  
DR. LYLE G. PHILLIPS

#### *Fee Adjustment Committee (for three years)*

DR. T. ALAN CASEY  
DR. THOMAS H. RICHERT  
DR. LAURENCE WIGG

#### *Library Board of Governors (for three years)*

DR. W. HAROLD CIVIN  
DR. ALBERT ISHII  
DR. ISAAC A. KAWASAKI  
DR. WAYNE WONG

After a brief message by the incoming president, the meeting adjourned to refreshments on the Lanai.

C. M. BURGESS, M.D.  
Secretary



# HMSA—Its Place in the Community

## Functions of the Committees

J. R. VELTMANN, *General Manager*

HMSA is a non-profit organization whose functions are similar to those of a club—members pay monthly dues for health protection, and the Association pays doctors and hospitals for services rendered its members for medical, surgical, and hospital care.

The governing body of HMSA is a Board of Directors composed of twenty-two public-spirited citizens who volunteer their services without compensation. The Board includes a representative from each of the major neighboring islands, as well as local industry, business, and other community activities. Nine Board members are doctors of medicine, and two are hospital representatives. Approximately one half of the members are elected at the annual membership meeting, and serve for a period of two years. The Board of Directors meets bimonthly to review progress, consider recommendations made by the various committees, and formulate future plans for the Association. Officers of HMSA are elected each year by the Directors from their membership. Members of this body are appointed by the President to serve on the active committees of the Association to study specific problems, review contemplated or necessary changes, and make recommendations for necessary action.

### *Active Committees*

1. Medical Committee: The nine doctor members of the Board of Directors serve on this committee, which functions as a liaison between the participating doctors, the members, and the Association. It reviews all medical problems and interprets technical medical procedures for HMSA and its members.

2. Finance Committee: This is an advisory committee on all financial matters of HMSA. It analyzes the budget, all budgetary changes or adjustments, financial statements, and investments.

3. Plans Revision Committee: This committee maintains a perpetual survey of the various plans offered to the public by HMSA in order to improve its services to members. All proposed changes in benefits and dues structure are reviewed by this committee before action is taken.

4. Sales and Promotion Committee: The advertising, promotional, and public-professional relations of HMSA are reviewed by this committee.

5. Coordinating activities and recommendations of these varied study groups is the important Executive Committee, policy-making body of HMSA, which is composed of officers of the Association, and chairmen of each of the subordinate committees.

(Next issue—Administration of HMSA)



# NOTES AND NEWS

## PERSONALS

**Dr. Edwin K. Chung-Hoon** addressed the Waikiki Lions Club in April on the subject of leprosy.

**Dr. and Mrs. N. P. Larsen** left for an extended trip to Europe. Dr. Larsen will spend some time as guest lecturer at the University of Uppsala, Sweden. Dr. Larsen has also been honored by being chosen as the recipient of the Fourth Annual Alumni Achievement Award of the Cornell University Medical College.

Also traveling abroad are **Dr. and Mrs. Fred K. Lam**. While in Spain, Dr. Lam will attend the International Surgical Conference to be held in Madrid in April.

**Dr. Albert H. Ishii** became the husband of Miss Faith S. Saiki at an impressive ceremony April 5, 1952 at the Makiki Christian Church.

**Dr. Ira D. Hirschy**, Director of the Division of Hansen's Disease of the Territorial Department of Health, addressed a Y.W.C.A. group at the University of Hawaii.

**Dr. and Mrs. W. H. Wilkinson** are parents of their fifth child, a son, Gerald Paul, born February 9, on Lanai.

Licenses to practice medicine in the Territory of Hawaii have been granted to **Drs. Walton M. Edwards, Thomas K. Oshiro, Thomas T. Harada, Richard C. H. Hitchen, James E. Mitchel, Gustav E. Rosenheim, and Carolina D. Wong.**

**Dr. Robert A. Kimmich**, psychiatrist and clinical director of the Territorial Hospital at Kaneohe, addressed the R. L. Stevenson P.T.A. on the subject of mental health.

Back after a three months study tour on the mainland is **Dr. E. W. You**, Director of the Department of Anaesthetics, at the Queen's Hospital. While away, Dr. You did special work at the Jefferson Davis Hospital, Houston, Texas.

Hawaii physicians called to active duty in the U. S. Army are:

**Captain Edwin B. Adams, Captain K. S. Chang, Captain Yasuyuki Fukushima, First Lieutenant Marion L. Hanlon, First Lieutenant Richard W. Neil, Captain William B. Simpson, and First Lieutenant Richard Y. T. Wong.**

**Major R. P. Wipperman** volunteered for service in Korea.

**Dr. William John Holmes**, News Editor of the JOURNAL, recently returned from an extensive lecture tour of the Far East and India. In Japan, Dr. Holmes served as a special ophthalmic consultant to the Surgeon General. In India, he was guest speaker at the 13th Annual "All India Ophthalmologic Conference." In New Delhi and Bombay, he spoke before the local ophthalmological societies. At Vellore he served as Visiting Professor of Ophthalmology at the Christian Medical College.

**Dr. Robert Faus**, Chairman of the Advisory Council to the Governor on Civil Defense, has been named "American of the Week" by the American Way Committee of the Honolulu Chamber of Commerce. Dr. Faus spoke on a program on KPOA on April 15 and 16.

**Colonel Dean Walker**, Chief, Department of Surgery, Tripler Army Hospital, is retiring from the Army after a distinguished career of twenty-five years. Colonel Walker is a graduate of the University of California Medical School, 1924. He is a fellow of the American College of Surgeons and diplomate of the American Board of Surgery. During the war, he was Commanding Officer of a 750-bed evacuation hospital in the European theater of operations. He will enter private practice, limited to general surgery, at Room 356, Alexander Young Building.

**Dr. Charlotte M. Florine** of the Medical Group recently toured the Pacific. She visited Fiji, New Zealand, and Australia, and stopped at Hongkong and Bangkok on her way back to Honolulu.

St. Francis Hospital announces the appointment of **Raid Chappell, M.D.**, pathologist, as full-time Director of the Laboratory.

Dr. Chappell received the degree of Bachelor of Science from the University of North Dakota. His degree in Medicine was obtained from Temple University School of Medicine. He served his internship at Reading General Hospital, Reading, Pennsylvania. As resident in pathology, he spent two years at Charity Hospital, New Orleans, one year at Albany General Hospital, Albany, New York, and one year at Kennely Hospital, Memphis, Tennessee. In addition, Dr. Chappell has had special training in Tropical Medicine, Pathology and Parasitology at Tulane University, New Orleans.

He holds membership in the American Society of Clinical Pathologists, the College of American Pathologists, and the American Society of Tropical Medicine.

Since 1951, Dr. Chappell has been at the Memorial Center for Cancer and Allied Diseases in New York City.

Dr. Chappell's wife, Dorothy, and his daughter accompanied him to Honolulu.

St. Francis Hospital also announces the appointment of **Miss A. Madeline Coles, R.R.L.**, as Medical Librarian. Miss Coles succeeds **Mrs. Antonia P. Burritt, R.R.L.**, who has been in charge of St. Francis Hospital Record Room for the past four years.

Miss Coles is a graduate of Hotel Dieu School of Nursing, Windsor, Ontario. She has been engaged in Professional Nursing in Detroit for four years and was with the United States Army for one year.

After two years at the University of Michigan, Ann Arbor, Mich., Miss Coles went to Mercy College, Detroit where she obtained her Certificate in Medical Library Science. As Record Librarian Assistant, Miss Coles has served at Samuel Merritt Hospital, Oakland, California, and Alameda Hospital, Alameda, California.

Our executive secretary and managing editor, **Mrs. Edith C. Bennett**, returned to her position at the beginning of February after an eight months' absence from the Territory. She had accompanied her husband, Professor J. Gardner Bennett, on an extensive tour of Europe and mainland United States during his sabbatical leave from the University of Hawaii. While in

Stockholm Mrs. Bennett represented Hawaii at the fifth annual meeting of the World Medical Association. She also spent a day in Geneva visiting the World Health Organization headquarters.

## Hawaii

### This is how it begins:

During the week beginning April 6, 1952, **Dr. Edward Wong** had been absent from his office. Could matrimony be the reason? Could be! But at the time of this writing, he couldn't be reached. Isn't that odd? We don't even know who the lucky gal is.

### And this is the result:

**Dr. and Mrs. Pete T. Okumoto** welcomed their third daughter on February 21, 1952.

**Dr. and Mrs. Hoei Higa** discovered themselves parents of a daughter on March 3, 1952—this is their first child.

**Dr. and Mrs. Nicholas Steuermann** have been playing the part of proud parents of a girl since March 13, 1952.

### Board-walk Bergin:

**Dr. William Bergin** vacationed on the mainland from March 13 to April 1, 1952. He attended the American Academy of General Practice Convention at Atlantic City from March 24 to 27. Next year, meet me at St. Louis, Bergi.

### A Mad Meeting:

The annual meeting of the Hawaii County Medical Society was held at the Hilo Country Club on March 29, 1952. The new officers for the 1952-53 fiscal year were elected. **Dr. S. Kasamoto** became president; **Dr. C. Hayashi**, vice-president; **Dr. R. Yamanoha**, secretary; and

**Dr. K. Ota**, treasurer. **Dr. Harry L. Arnold, Jr.** was our guest speaker. He was also voted the best joker.

### The Auxies met too:

The woman's auxiliary to the Hawaii County Medical Society had its annual dinner meeting on April 2 at the Lanai. **Mrs. T. D. Woo** was elected president; **Mrs. S. Mizuire**, vice-president; **Mrs. S. Kasamoto**, secretary; and **Mrs. William Bergin**, treasurer. During the past year, the auxiliary maintained beautiful floral arrangements in the reception room and corridors of the Hilo Memorial Hospital.

### Civil Defensing:

On April 8 **Dr. Richard K. C. Lee**, assistant health officer of the territorial board of health, spoke to the drugs and supplies committee of the local Civil Defense.

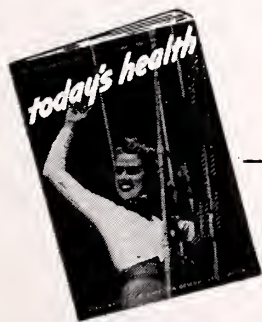
## NEWS

### Postgraduate Course in Psychiatry and Neurology

The Division of Psychiatry, University of California School of Medicine, is offering to qualified physicians a postgraduate course covering the most recent developments in psychiatry and neurology under the direction of **Dr. Karl M. Bowman**. The course will be held at The Langley Porter Clinic in San Francisco for ten weeks, beginning August 25. It is designed to prepare psychiatrists and neurologists for the American Board examination. Further details may be obtained from The Langley Porter Clinic, The Medical Center, Parnassus and Third Avenues, San Francisco 22, California.

*today's health*  
a must!

for your  
reception room



Physicians'  
Half-Price Rates

4 years	\$ 4.00
3 years	3.25
1 year	1.50

AMERICAN MEDICAL ASSOCIATION  
535 North Dearborn · Chicago 10, Illinois

*In very special cases  
A very superior Brandy*



*Specify*

84 Proof

★ ★ ★  
**HENNESSY**  
THE WORLD'S PREFERRED  
COGNAC BRANDY

Schieffelin & Co., New York N. Y.

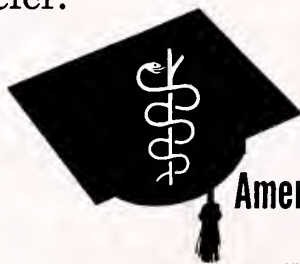




**\$13,356**

America's  
medical schools graduated  
6,135 new doctors  
of medicine last year.  
It cost \$13,356  
to train each of them.

Most of this becomes medical school operating deficit which we as a profession must help meet. We will send your contribution along to the medical school of your choice if you prefer.



**American Medical Education Foundation**

535 North Dearborn Street, Chicago 10 -

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

---

LEONA R. ADAM, *Executive Secretary*, Honolulu

## BULLETIN COMMITTEE

CLAIRE CANFIELD, *Editor*, Board of Health, Honolulu

LORETTA SCHULER, *Nursing Information Committee*, ARC, Honolulu

JUNE APO, Honolulu

ALICE SCOTT, Honolulu

MARJORIE ELLIOTT, Honolulu

MARGARET BARNETT, Hawaii, *Secretary*

JOANN GROBERG, Maui, *Secretary*

MYRNA CAMPBELL, Kauai, *Secretary*

GLADYS LEONG, Oahu, *Secretary*

---

## THE CHALLENGE OF CHRONIC ILLNESS

DORIAN PASKOWITZ, M.D.

Old Age

PO CHU-I (835 A.D.)

*More Translations from the Chinese* by Arthur Waley.

Po Chü-i was 63 when this was written. Several years thereafter he had a stroke, and not many years later died of this chronic illness.

*We are growing old together, you and I  
Let us ask ourselves, what is age like?  
The dull eye is closed ere night comes;  
The idle head, still uncombed at noon.  
Propped on a staff, sometimes a walk abroad;  
Or all day sitting with closed doors.  
One dares not look in the mirror's polished face;  
One cannot read small-letter books.  
Deeper and deeper, one's love of old friends:  
Fewer and fewer, one's dealings with young men.  
One thing only, the pleasure of idle talk,  
Is great as ever, when you and I meet.*

This poem was written to a friend, who was born in the same year as the poet.

Perhaps it would be wise before beginning a discussion on the subject of chronic illness to define the terms chronic disease, chronic illness, and chronic disability.

Broadly speaking, chronic disease refers to the underlying pathology which, unless arrested, results in chronic illness. Such a disease is often unknown to the individual concerned. Chronic illness refers to the condition, permanent or recurrent, which ultimately results in a long period of medical care or supervision. Chronic illness may result in a greater or lesser degree of chronic

disability. In essence then chronic disease is a change in structure, function, a distinctive pathologic change in the body, and this permanent change which occurs as the result of the disease, known or unknown to the patient, unless arrested, produces chronic illness and disability.

With these definitions to guide us, which are the most important chronic diseases? Here are twelve we can list: heart disease, arteriosclerosis, and hypertension, nervous and mental diseases, rheumatism, kidney disease, tuberculosis, cancer and other tumors, diabetes, asthma, and hay fever. If we combine statistics on prevalence, mortality, disability and invalidism, these foregoing diseases stand out as most significant. These diseases are distinguished as in their definition by their long duration or recurrent nature; they are distinguished by the considerable amount of medical care over a long period of time, perhaps a lifetime, which is necessary in order to deal with them.

Let us reflect for a moment upon our traditional attitudes regarding the chronic diseases and regarding chronic illness. We have, in the last several years, changed from a passive attitude of pessimism regarding these conditions to an attitude of optimism today when we realize what can be done to prevent or arrest these conditions.

In the past, our attitude toward the chronic diseases was such that we considered them as terminal illnesses, diseases requiring domiciliary care, diseases we felt nothing much could be done about.

Where then does this present optimism come

Read before the annual meeting of the Nurses' Association, Territory of Hawaii, October 18, 1951.



from regarding these conditions? I believe considerable hope comes from looking back over the excellent results obtained through prevention and successful treatment of some of the chronic infectious diseases, which have been successfully managed in the last twenty to twenty-five years. Our excellent results in syphilis, tuberculosis, and malaria give realistic confidence as to what can be done in some areas of the chronic diseases. Also, with excellent rehabilitation methods and technics, we have been able to change persons with certain major disabilities, invalids, to partially self-sustaining individuals through these modern technics. Results from two world wars have been instrumental in developing these methods.

There is another traditional attitude which sometimes stifles our interest in chronic illness. It is a frequent attitude, is it not, to think of patients with the chronic diseases as being old, aged, and infirm, of thinking of the medicine applied to such patients as being "dirty medicine" so to speak. We have helped to displace this by even popularizing a new term for the care of old folks and their diseases—geriatrics.

I would like, here, to express what I believe is the first fundamental concept worth emphasizing in a discussion of chronic disease and chronic illness. Chronic illness is not just a problem of old age; chronic diseases are not exclusively the diseases of the aged and the old. Yes, it is true that chronic illness rates rise rapidly with age, but I believe we are wrong in identifying chronic disease as largely an old-age problem.

#### *Chronic Illness Rates Rise Rapidly With Age*

Estimated No. 5-Year Incidence Rates	
AGE	RATE, OCCURRENCE, NEW CASES OF CD PER 1,000 POP.
25 Years	35
45 "	100
60 "	250
80 "	575
90 "	900

In the age group 5 to 25, new cases of chronic disease are approximately 35 per thousand in five-year incidence statistics. By the time we reach the age group of 60, new cases of chronic disease rise rapidly to 250 per thousand and by 90 rise to 900 per thousand. But, herein is a significant fact: the National Health Survey 1935-1936 showed that more than one-half of the persons, more than 50 per cent of people, with chronic disease and one-third of invalids in the nation are under the age of 45, and more significantly, 16 per cent of those with chronic disease are under the age of 25.

Many important chronic diseases, such as

rheumatic fever, rheumatism, and arthritis and certain phases of diabetes, heart disease, and poliomyelitis characteristically occur in childhood or early adult life.

What are some of the reasons for our new awakening, our new concern regarding the chronic diseases and chronic illness? First, with the marked decline of acute infectious diseases, leading causes of death have changed very significantly in the interval between 1900 and 1947. A chart will show the change in leading causes of death that has resulted in the last fifty years or so.

#### *Changes in Types of Diseases Causing Death*

1900	Leading Causes of Death	1947
1. Pneumonia and Influenza		1. Diseases of the Heart
2. Tuberculosis		2. Cancer
3. Diarrhea and Enteritis and Ulceration of the Intestines		3. Intracranial Hemorrhage of Vascular Origin
4. Diseases of the Heart		4. Nephritis
5. Senility, Ill-Defined and Unknown Lesions		5. Accidents, Excl. of Motor Vehicle
6. Intracranial Hemorrhage of Vascular Origin		6. Pneumonia and Influenza
7. Nephritis		7. Tuberculosis
8. All Accidents		8. Premature Births
9. Cancer and Other Malig. Tumors		9. Diabetes
10. Diphtheria		10. Motor Vehicle Accidents

It is obvious that as we conquer one disease, another disease which we have been less concerned with takes prominence.

It is also evident that as we continue to destroy the diseases which destroy man early in his life, then, those diseases characteristic of an older age group become more prominent. Our population structure is changing very considerably. We have a rapidly aging population. In the last fifty years, our life expectancy has increased over 35 per cent. In 1900, 18 per cent of the total population in the United States was 45 years or over; by 1940, 27 per cent of our total population was 45 years or over. And if we draw out this fine line of prediction to the year 1980, it is estimated that 36 per cent of the total population of the United States, over one-third of our total population, will be in the age bracket 45 years and over. At present the population structure of Hawaii is similar to that of the mainland fifty years ago. Our population is still relatively young in character.

Economic factors have served strenuously to focus our attention on the chronic diseases. In a time of plenty, when relief rosters were dwindling in size, it became evident that a significant amount of economic dependency was caused by chronic disease and chronic illness within a family unit. At this point, I should like to state in several ways what I believe is the second fundamental concept in regard to chronic illness. Poverty creates chronic illness, and chronic illness, in turn, creates poverty. Chronic disease is most common in that segment

of the population least capable of bearing its cost; namely, the low-income and welfare groups. In other words, there is an inverse relationship between chronic disease and economic status. A few figures may help to emphasize this concept: once again, referring to the National Health Survey, this survey revealed that the prevalence of chronic disease was almost 90 per cent higher among persons on relief than among those with family incomes of \$3,000 and over. In non-relief families with incomes of less than \$1,000, the incidence of chronic disease was over 40 per cent higher than in families with incomes of \$3,000 a year or more.

These statistics exemplify this fundamental principle regarding the relationship between chronic disease and economics. If we are to make any dent in our welfare rolls, which have enlarged to somewhat critical proportions already, we are going to have to find some way to decrease the burden of chronic disease and chronic illness now borne by our low-income population or being passed on to the community at large.

Another important reason which directs our attention and makes us more aware of the immediacy of the chronic illness problem is the tremendous drain upon existing medical care and hospital facilities imposed by chronic illness. It is very meaningful to realize that about 40 per cent of all services of a physician in home, office, and clinic are now given to the care of chronic illness; 3 out of every 4 hospital patients in the United States are hospitalized for chronic physical or mental disease. Once again, let us extend our rates into the year 1980. By 1980, if the current trends increase, the following services will be required in *addition* to those services required solely on the basis of population growth: almost 11 million additional medical consultations will be required; almost 7 million patient days of hospital care will be required, and 4 million additional days of nursing care would be required. Remember, this is in addition to the increases which will come about merely from the increase in population. If present levels of service are to be maintained, by 1980 there will have to be a 20 per cent increase in hospital and physician services to meet the immediate demands of chronic disease patients alone.

Lastly, I believe our interest in chronic illness has increased nationally because living in an era where man-power demands for the preservation of national security are needed in great magnitudes and over a continuing period of time, we are

deeply concerned over the loss of productive capacity as a nation as a result of chronic diseases and chronic illness. It is estimated that nearly a billion days of productive activity are lost yearly from chronic diseases. This is not a time when such waste of productivity can be easily reconciled.

### Brief Review of the Extent of the Problem

We can readily understand now why the medical profession eyes with grave concern these changes in health trends, which, for instance, in the short span of forty-seven years, have seen leading causes of death from pneumonia, influenza, tuberculosis, diarrhea, and other enteric diseases replaced by heart disease, cancer, intracranial hemorrhages, and nephritis; the striking change from acute infectious diseases to chronic degenerative diseases as major causes of death. Public health workers are quite aware of the implications of the aging population and the chronic disease burden this variation in social structure has and will impose upon health agencies.

Struck with the immediacy of knowing that by 1980, 20 per cent increase in physician services will be needed and that four million days additional of nursing care will be necessary, organized physicians and nurses have begun mapping a strategy to meet this challenge.

Hospital administrators now view with alarm the monopoly of hospital beds by patients suffering from the chronic diseases. They are quite aware of the difficult position of having to find beds for patients with acute diseases when three out of four patients hospitalized are in hospitals for some chronic physical or mental disease.

And, of course, the welfare worker and the social worker also are quite justified in being moved to interest and action when they realize that the prevalence of chronic disease is 90 per cent higher in persons on relief as compared to individuals with family incomes of \$3,000 a year and over. All of this adds up to a combined concern of every health agency and every member of the health profession.

What is the answer then? How are we ever going to decrease this growing debt upon the people and the resources of our nation and our community? Certainly this presents a great challenge, and certainly the majority of methods have yet to be worked out for a satisfactory solution of this problem. It is here that I think a statement regarding preventive measures is very much in order.

It is self-evident that the basic approach to this



problem must be a preventive one if these debts are not to accrue. Various national, state, and local agencies have tried to point out some common denominator in the matter of prevention of chronic disease. It has been pointed out in an article written by Dr. Morton Levin, a prominent authority in the field of chronic illness control, "unless the basic approach to chronic disease is preventive, the problems created by the chronic diseases will grow larger with time and hope for any substantial decline in their incidence in severity will be postponed many years." This, I believe to be the third fundamental concept worth emphasizing in a discussion on chronic illness.

There are two basic types of prevention of the chronic diseases. The first we might call primary prevention, which is the prevention of the chronic disease from occurring at all or removal of the presenting or the immediate causes for such diseases. The job of knowing and understanding these causes is still primarily a research problem.

Secondary prevention can be considered as our attempts through early detection in screening and early diagnosis of disease in apparently well people, to make available early treatment which may prevent or at least delay progression of the disease. Prevention has to be applied to persons in the population that are apparently well.

As was mentioned before, there are some chronic diseases for which we have already established preventive programs, which have been extremely successful. Examples of these were mentioned: syphilis, tuberculosis, and malaria. We must now apply information already known on all of the chronic non-infectious diseases. Through intensified application of present knowledge, control of these diseases will certainly be forthcoming.

Probably the most direct job in prevention is that which, as mentioned, relates to basic research. The satisfactory outcome of research to find the hidden causes of many of the chronic diseases will undoubtedly yield grand rewards.

But we cannot wait for the unknown. Prompt and effective known treatment will apply as rewardingly to the yet unconquered, non-communicable chronic diseases, and there is an immediate job to bring to bear already existing information in order to effect control. Early recognition is extremely important in the prevention of chronic illness and chronic disability from the chronic disease which is the second leading cause of death—cancer.

Educational campaigns continually are needed

to encourage apparently well persons to submit to periodic health examinations. The mass x-ray survey, as a casefinding technic for chronic disease, has been most successful in our own community. Another good example is the education aimed at decreasing the mortality from cancer of the breast. Certainly, we are all familiar with those optimistic results produced from early recognition and early treatment in cancer of the breast.

Realization of the need for prevention if we are to make any dent in the chronic illness problem, and careful study of the means by which such prevention can be accomplished, have led to a resolving of certain common factors which are necessary in any chronic illness program and which, in managing one chronic disease, are and will be successful in taking care of another. These common factors include satisfactory methods of detection for chronic diseases—early diagnosis of chronic disease, satisfactory hospital care, and, of course, nursing home care and home care to meet the demand for services which cannot be filled by present hospital resources. And finally, rehabilitation and domiciliary care of persons who have chronic illness. This complex of activities from detection to rehabilitation is the common approach to all of the major chronic diseases. The awareness of this common approach has been the impetus for organized medical public health, hospital and public welfare representatives to combine forces in an attempt to combat chronic illness through the use of these common factors which can be applied to all of the chronic diseases.

How important it is going to be for the ultimate success of our battle against chronic illness to achieve the highest degree of cooperation in order to implement the common factors necessary to effectively control the chronic diseases!

In a cooperative atmosphere, we will collectively first need to gather information regarding the extent and nature of our problem locally. We will have to bring to bear the very best kind of administrative activities to keep all phases of action, from early detection to rehabilitation and domiciliary care, functioning smoothly and in concert with other of the vital activities. We will have to wage a broad educational campaign to convince people of the positive aspects of chronic illness; and finally, we will have to develop specific programs to meet our local needs. Only through such a cooperative effort can we have any hope of effectively meeting the most significant health problem of our day.

## UNIVERSITY OF HAWAII SCHOOL OF NURSING

Virginia Jones\*

The Board of Regents of the University of Hawaii, on April 1, authorized the development of a four year curriculum in nursing at the University.

Beginning September 1952, high school graduates who meet requirements for admission may pursue a program of combined academic and professional courses which will lead to a bachelor of science degree in nursing, establish eligibility to apply for examination with the Territorial Licensing Board, and prepare them for public health nursing positions.

This development, in keeping with leading medical centers on the mainland, derives from recommendations made for several years by the Territorial Nurses Association, the Honolulu Chamber of Commerce, Dr. Ira Hiscock's health survey of 1951, and the Legislative Hold-Over Committee of 1950-51. Continued operation of the school, however, will be dependent on adequate appropriation being made in the 1953 Legislature.

The aim of the school is to prepare nurses to participate in disease prevention and health promotion programs on a community level, to give competent bedside care and health instruction in either hospitals or homes. It aims also to give nurses a sound foundation for advanced education in preparation for teaching and supervisory positions.

Requirements for admission to the basic professional nursing program will be the same as for other prospective university students with the addition of satisfactory results in nursing aptitude tests, physical examinations, interviews, and references. Nursing students will be responsible as are other students for their own living arrangements and expenses, and the usual health, dormitory, and guidance service will be available to them.

The first year will be similar to that of other colleges with the addition of introductory courses in nursing, designed to be useful even though the student does not continue in the nursing school. Clinical practice in hospitals will begin in the second year, and will continue during the third and fourth years with additional practice in rural public health and hospital services in the senior year.

To complete the program in four years will

require eleven months of work each year, that is, enrollment in courses each semester, in the summer session, and in a four week period following the summer session.

Enrollment will be limited to 25 students for the first few years.

Hale Aloha, a building formerly in use as a girls' dormitory and more recently as housing for faculty members, has been assigned the School of Nursing for offices, classrooms, and a nursing arts laboratory. Funds have been made available to purchase equipment for this building through the generosity of the McInerny Foundation, the G. N. Wilcox Trust, the Charles M. and Anna C. Cooke Trust, the Watumull Foundation, the Frear Eleemosynary Trust, and A. R. Keller, formerly Dean of Applied Sciences at the University of Hawaii.

Practice facilities for clinical experience will be developed in local hospitals, in nursery schools, and in institutions and homes caring for convalescents, chronically ill, and aged.

The development of the University School of Nursing is not intended to supplant schools now conducted by St. Francis and the Queen's Hospitals. It aims primarily to provide opportunity locally for collegiate work in nursing for those who want it, and also to reduce the necessity for depending upon mainland graduates. Nor will the basic school delete curricula preparing graduate nurses for public health nursing, supervision, and clinical teaching. These courses, offered by the University since 1943, will be continued in the School of Nursing.

Graduates of the four year curriculum will be prepared to accept staff positions under supervision in hospitals and public health agencies, also private duty and office nursing. In line with the trend requiring the bachelor's degree for admission to programs preparing for supervision, teaching, and specialized clinical practice, graduates of this curriculum will be eligible for such programs on a master's level.

The development of a School of Nursing in the University of Hawaii, which offers a combined professional nursing and academic program leading to a bachelor's degree, as stated above, is in line with mainland developments. One hundred and five such schools were functioning in the United States in 1950. More are being developed. Collegiate programs are now available in all but eight states, California presently offering eight such programs.

\* Director, University School of Nursing



### ALOHA, MISS EYMAN!

Dr. Rodney T. West, Chairman of the Board of Management of the Mabel Smyth Memorial Building, has announced the retirement of Miss Jessie Eyman.

Miss Eyman, who came to Hawaii in 1924, was one of the founders of the Physicians' Exchange, and has been the manager of the Mabel Smyth Memorial Building since it was opened eleven years ago. Miss Eyman's association with the building, however, goes back even further than that, for she was present at the meeting of the Nurses' Association on March 10, 1938, when the first mention was made of combining the Medical Library and the Nursing Service Bureau and of investigating the possibility of The Queen's Hospital's giving up a part of its land for the location of such a building. This was one of the meetings which Mabel Smyth, herself, attended.

Dr. West remarked that the Board was sorry to see Miss Eyman leave because she is one of the few people who really knows the entire picture with regard to the operation of the building, and she would be sorely missed by everyone. He also announced that Mrs. Illa Storme, who is now in charge of the Physicians' Exchange and Nursing Service Bureau, would be the new manager of the building and would assume her new duties on June 1, 1952. Mrs. Storme has had some previous experience in managing the building, for she relieved Miss Eyman during the latter's leave of absence in 1948-49.

Miss Eyman stated that she plans to spend her leisure time on a ranch in California, and in travelling. So if she follows the usual pattern of others who have left Hawaii to retire on the mainland, we will no doubt see her back in Honolulu before too long.

We all want to wish Miss Eyman a healthy, happy retirement.

### THE QUEEN'S HOSPITAL SCHOOL OF NURSING PIN

Rosie K. Chang\*

A great deal of sentiment and royal interest is attached to the history of The Queen's Hospital School of Nursing pin. Her majesty, Queen Liliuokalani, the last ruler of the Royal Hawaiian Kingdom, designed the pin for the newly established School of Nursing in 1916. She suggested her personal motto, "Onipaa", the English of which is "Steadfast" or "Be Firm," as the school's motto. "Onipaa" is engraved in gold in the center oval of the pin. The words "Queen's Hospital School

of Nursing" are imprinted in gold on a purple background encircling the motto. A gold fluted border completes the oval pin.

The colors of the pin and school are the royal colors of Hawaii.

### KAUAI ATOMIC NURSING INSTITUTE

March 11, 12, 1952

Wilcox Memorial Hospital Nurses' Home

The Atomic Nursing Institute was held under the sponsorship of the Nurses' Association, County of Kauai. Approximately 80 professional and practical nurses attended the sessions in spite of the cold, wet, windy weather that prevailed.

Dr. Dorian Paskowitz, Mr. B. J. McMorro and Mrs. Rosie K. Chang were participants from Honolulu.

Nurses from both East and West Kauai were very well represented. There was active discussion and participation on how Kauai should implement their program. Several resolutions resulted of which one was the setting up of an Emergency Mobile Unit. If this is carried out, it will be the first mobile unit organized in the Territory.

### BOOK REVIEW

*Care of the Medical Patient.* By Margene O. Faddis, R.N., M.A., and Joseph M. Hayman, Jr., M.D., 654 pp., price \$4.50. McGraw-Hill Book Company, New York, Toronto and London, 1952.

The emphasis in this text is placed on the individual rather than on his ailment. It concentrates on the diseases which are likely to have residual effects on the patient necessitating special care and rehabilitation. Several very complete case histories, describing the nurse's role as an educator who helps the patient to learn to care for himself and shows his family how they may share in his care, aid in this personal approach.

This book should prove most valuable as a reference text for medical nursing. Medical terminology is well explained in language that all students should easily understand. Constantly stressed is the fact that mechanical devices, manual skills, "starched efficiency" and the like do not constitute *good* nursing. Since the nurse may flawlessly perform procedures and yet show a shocking failure to recognize the essential indivisibility of the patient whom these procedures are designed to help, emotional factors are considered in detail "because understanding is often far more important than manual skill and is frequently more difficult to acquire."

—DOROTHY B. VAN DERHYDEN, R.N.

Clinical Instructor, The Queen's Hospital School of Nursing

### NURSES' ASSOCIATION, DISTRICT OF HAWAII

The Nurses Association, District of Hawaii, celebrated its 25th anniversary on April 1 with a dinner meeting at the Hilo Hotel.

Six charter members of the organization were honored. They were Mrs. Mae Marcallino, incumbent president, Mrs. Josephine Victor, Mrs. Kate Lawson, Mrs. Ethel McGuinness, Miss Margaret Campbell, and Miss Helen Gorsuch.

Miss Leona Adam, Executive Secretary, Nurses Association, Territory of Hawaii, was guest speaker.

\* Educational Director, Queen's Hospital

The topic for discussion was "The ANA Wheel of Life." The central core or "hub" of this wheel, she stated, is Public Relations. The spokes of the wheel are representative of services made available through membership in the ANA. These, (1) International Program, (2) Nursing Service, (3) Membership, (4) Legislation, (5) Economic Security, (6) Counseling and Placement, (7) Research, and (8) State Boards of Examiners, were reviewed briefly, and the advantages which automatically accrue from membership and participation were stressed. Maintain membership: "You need your professional association—and your professional association needs you."

Miss Mary Stanley, formerly with Puumale Hospital, now retired, is currently playing a part in the Community Theatre production, "The Curious Savage."

Mrs. Peggy Wiperman, Director of Nurses, Hilo Memorial Hospital, recently returned from Japan where she spent ten days with her husband, Dr. R. P. Wiperman, who is on duty with Armed Forces in Korea.

Mrs. June McGee, Pediatric Nurse, Hilo Memorial Hospital, plans to join her husband in Seattle, Washington, early in May.

Miss Clara Mitchell, Hilo Memorial Hospital, will leave for the Mainland the first of May for an extended visit with her parents in California.

Mrs. Jean Ikawa, Hilo Memorial Hospital, with her husband Kenji and young daughter will leave Hawaii in April to make their home on the Mainland.

Recent marriages of nurses on staff at Hilo Memorial Hospital were Phyllis Adversalo to Mauricio Valera and Kagumi Saigo to Yoshito Tanaka.

Weddings are noted also among nursing staff of the Department of Health: Laura Gibu to James Sugai, February 9, 1952; Soon Yur Kim to Kiyoyuki Nakatsu, April 12, 1952; Dora Lum to Toshiaki Hayashida, May 10, 1952.

New arrivals in the community: To Mrs. E. C. Moore, nee Eleanor Park, a former public health nurse, a son, William Lee, born February 26, 1952. To Mrs. Robert Moore, nee Eleanor Saunders, former plantation nurse, Paauhau, a daughter, Patricia Helen, March 17, 1952.

Miss Loretta Schuler, Director of Nursing Service, American Red Cross, arrived in Hilo April 1 to hold classes for nurse instructors in "Home Care of Sick." Two sessions daily are planned, one 8 to 10:30 p.m., and another 7 to 9:30 p.m., to extend over a three week period. Initial enrollment numbered eighteen persons.

## NURSES' ASSOCIATION, KAUAI DISTRICT

Miss Marilyn Estill is visiting her family in California. On return she plans to work on Maui.

Miss Florence Minami, who has been a member of the Wilcox Memorial staff for the past year, is now nursing at Kuakini Hospital in Honolulu.

Miss Elizabeth Middleton, Superintendent at Wilcox Memorial Hospital, accompanied by Miss Barbara Davis, has left for a month's vacation on the West Coast.

Miss Yaeko Konishi, a member of the Mahelona Hospital staff for the past year, was married to Mr. Isao Ito, March 22, 1952, and is now making her home in Wahiawa, Oahu.

## NURSES' ASSOCIATION, DISTRICT OF OAHU

The Nurses' Association, District of Oahu, announces the following committee chairmen appointments: Pro-

gram, Leona Rubbelke, Dept. of Health; Membership, Alavana Chang, Dept. of Health, Kapahulu; Arrangements & Refreshments, Susan Medeiros, Dept. of Health, Lanakila; Hostess, Ann Camara, Leahi; Blood Bank, Margaret Makekau, Dept. of Health, Lanakila; Nursing Information, Flora Ozaki, Dept. of Health; Finance, Alice Shida, Queen's; Constitution & By-Laws, Evangeline Cook, Children's; Nominating, Margaret Nott, Kapiolani; Disaster, Virginia Jones, University; Courtesy, Clara Bellevue, Dept. of Health, Kapahulu.

## Blood Bank Reserve

Mrs. Margaret Makekau, Chairman, Blood Bank Committee, District of Oahu, wishes to remind members that contributions to the Blood Bank Reserve are urgently needed. She reports that donations to date total 19; the number since January 1 only 5. Mahalo nui loa to those who have contributed. Will not you too give a pint now!

Mrs. Mabel Davis has been employed as nurse instructor to conduct group sessions in prenatal care for patients registered with obstetricians at the Straub Clinic. Classes, held on Tuesdays and Fridays from 9-11 a.m., are designed essentially to orient primiparas; however, other mothers, on request, may participate.

Mrs. Davis, a graduate of the Hospital for Women and Children in San Francisco, received her certificate in Public Health Nursing from the University of Hawaii, and subsequently worked in Waipahu for several years. Lately she has been teaching classes in Home Nursing, and Mother and Baby Care for the American Red Cross, and to nurses in the Public Health Student Program at the University of Hawaii.

Miss Laura Draper, former Chief of the Bureau of Public Health Nursing, Department of Health, returned on March 30 from an extended vacation in New Zealand and Fiji. She plans to remain in Honolulu three or four weeks, then go on to Tucson, Arizona. Her accounts of the land "down under", the people, their life and customs, and not to be overlooked, the nursing situation, are most graphic and entertaining.

## St. Francis Hospital

Mrs. Norma Larsen who has been with the St. Francis Hospital for several years, first as evening administrative supervisor and then as the supervisor of the second floor, delivered a baby boy weighing 9 pounds 2 ounces on March 13, 1952. Norma and her husband, Alfred, have decided to call the baby Mark.

New nurses on the St. Francis Hospital staff are as follows: Miss Anna Mary Burke who is a graduate of St. Mary's Hospital School of Nursing in Duluth, Minnesota, and who has her B.S. in Nursing Education from the College of St. Scholastica, will fill the position on the school of nursing faculty vacated when Mrs. Ora Mae Lytle, nursing arts instructor, returned to the Mainland with her family.

Miss Edith Kubojiri who is a graduate of St. Francis Hospital School of Nursing returned from post graduate studies in premature nursing at County General Hospital, Los Angeles, California. Miss Kubojiri received scholarship assistance for this advanced preparation from the Bureau of Maternal and Child Health.

Miss Bethel Ann McKeen who is a graduate of Valley College of Nursing, San Bernardino, California.

Miss Louise Weekes who is a graduate of the Massillon City Hospital School of Nursing, Massillon, Ohio and who has her B.S. in Nursing Education from Ohio State University.



Miss Inez Lange who was the nursing arts instructor at St. Francis Hospital School of Nursing from September, 1945 to July, 1950 is now the educational director of the Minneapolis General Hospital in Minneapolis. She is finding her position very interesting and very challenging.

Miss Anna Fisher who was the associate in nursing education at the St. Francis Hospital School of Nursing from 1947-1949 has finally published her workbook in Microbiology.

Miss Karen Tanaka will receive her B.S. in Nursing Education from the University of Dayton this summer and will join the faculty of St. Francis Hospital School of Nursing early in June. Miss Vivian Zane will complete the work necessary for a B.S. in Nursing Education by February of 1953 and will return soon after. Both of these young women received scholarships from the Board for Licensing of Nurses, Territory of Hawaii, through the Territorial Legislature Scholarship Fund.

Miss Juanita Soo who attended the University of Hawaii from September, 1948 to June, 1949 and who graduated from the St. Francis Hospital School of Nursing in September of 1951 is also matriculating at the University of Dayton.

New officers of the St. Francis Hospital Alumnae Association for 1952 are as follows: President, Mrs. Marjorie Oguro; Vice-President, Mrs. Amelia Garcia; Recording Secretary, Miss Esther Aranio; Corresponding Secretary, Miss Rosario Dela Cruz; Treasurer, Miss Eleanor Enomoto; Director, Mrs. Haruko Obara.

## JOB OPPORTUNITIES

Applications are being received for the position of Director, Nursing Service Bureau and Physicians' Exchange. Nurses interested in this position should direct their inquiries and applications to Mrs. Illa Storme, N.S.B.

The Trust Territory of the Pacific Islands has openings for two American nurses with successful supervisory experience. The positions involve supervision, demonstration and instruction of native island nurses in the district hospitals of the Trust Territory, including the Carolines, Marshall and Mariana Islands.

The hospitals are staffed by American physicians and native island interns. Qualifications of good technical performance, tact, sympathy, and a spirit of good will are necessary.

For further information, contact the Personnel Department, Trust Territory of the Pacific Islands, Building 87, Fort Ruger, Honolulu, or address mail to 3845 Kilauea Avenue, Honolulu 16.

## PROFESSIONAL COUNSELING AND PLACEMENT SERVICE

### Positions Available

#### *Honolulu and Oahu:*

Director of Nurses  
\$400  
Supervisor Obstetrics (2)  
\$300 - \$375  
\$265  
Supervisor, Medical-Surgical Dept.  
\$250 - \$295  
Nurse Anesthetist  
\$325 - \$345  
Physical and Biological Science Instructor  
\$290 - \$315  
Public Health Nursing Coordinator  
\$280 - \$300  
General Duty  
\$218 - \$238  
\$230 - \$240  
\$223 (\$45 month maintenance)  
\$250 plus maintenance  
Clinical Instructor—Medical-Surgical Dept.  
\$260 - \$280  
Supervisor—Surgery  
\$275  
Hansen's Disease Program  
\$244 - \$282

#### *Molokai:*

Hansen's Disease Program  
\$244 - \$282  
General Duty  
\$260 plus maintenance

#### *Maui:*

General Duty  
\$227 - \$262 plus maintenance  
\$240 (Room \$10 month; meals 30 for \$10)  
Supervisor—3-11  
\$280

#### *Kauai:*

Night Supervisor  
\$260 plus maintenance  
Ward Supervisor  
\$227 plus maintenance

#### *Hawaii:*

Plantation Hospital  
\$275 plus lunch  
Nurse Anesthetist  
\$300  
General Duty  
\$262 - \$282 (\$30 month deducted for room, board, laundry)  
Plantation Dispensary  
\$285 plus house  
Educational Director

#### *Territorial:*

Public Health Nursing  
\$3150 - \$3890 yearly

#### *Canton Island:*

Dispensary  
\$5046 per year

#### *Trust Territory:*

Chief Nurse (2)  
\$400  
Supervisor  
\$500

There are several positions open for practical nurses.

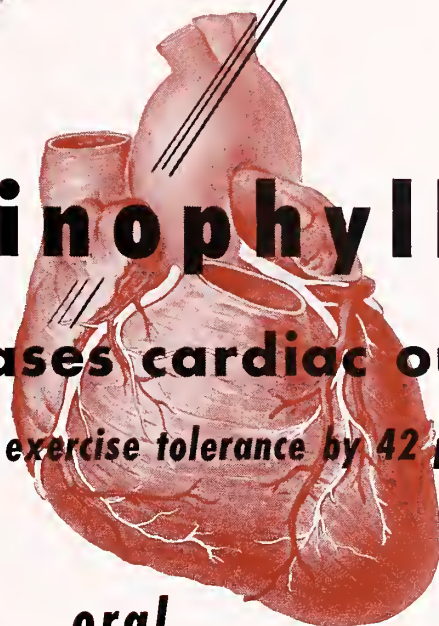
For further information regarding qualifications, personnel policies, etc., contact Miss Leona R. Adam, Counselor, Professional Counseling & Placement Service, Nurses' Association, Territory of Hawaii, Mabel Smyth Building.

**SEARLE**

# **Aminophyllin\***

**increases cardiac output**

*"improves exercise tolerance by 42 per cent"<sup>1</sup>*



**oral  
parenteral  
rectal dosage forms**

**Indicated in:**

*Dyspnea of Congestive Heart Failure*

*Bronchial Asthma*

*Status Asthmaticus*

*Pulmonary Edema*

*Control of Cheyne-Stokes Respiration*

**Also of value as:** *Peripheral Vasodilator<sup>2</sup>*

1. Kissin, M.; Stein, J. J., and Adelman, R. J.: *Angiology* 2:217 (June) 1951.

2. Rickles, J. A. J. *Florida M.A.* 38:263 (Oct.) 1951.

\*Contains at least 80% of anhydrous theophylline.



**SEARLE**

**RESEARCH IN THE SERVICE OF MEDICINE**



# ANNOUNCEMENT

*As you probably know, Clinton D. Summers  
became the sole owner of . . .*



**McARTHUR & SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 6-6D44  
6-8B65

THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAII

EMERGENCY PHONE  
7-8411

AT THIS TIME WE WISH TO ANNOUNCE  
THAT HENCEFORTH  
THE FIRM NAME WILL BE



**CLINTON D. SUMMERS**

**PRESCRIPTION • PHARMACISTS**

PHONES 66-0-44  
68-8-65

THIRD FLOOR - YOUNG BUILDING  
HONOLULU, HAWAII

**Statement of Policy:** The sole aim of this pharmacy is to continue to strive to BETTER SERVE the Medical and allied professions, and their patients . . . with an alert, skillful, and conscientious pharmaceutical service. Only by constantly seeking perfection can this goal be achieved.

Thank you,

CLINTON D. SUMMERS

**Now**  
**another important advantage of Thiomerin:**



## Suitability for Home Administration

The self-injection of the thionated mercurial diuretic, Thiomerin, has now become a well-established procedure for patients who have congestive heart failure, just as the self-injection of insulin has long been a well-established procedure for patients who have diabetes.

Numerous authorities<sup>1-12</sup> recommend Thiomerin for home administration because it is as well tolerated and predictable in effect when given *subcutaneously*, as when given intramuscularly and intravenously. The technique of injecting Thiomerin Sodium may be quickly mastered.

Consequently, more and more physicians are finding that it is often desirable to instruct the patient or a member of his family in the use of Thiomerin so that injections between visits can be made on schedule—according to the dosage plan that best suits each patient.

A supply of *printed instructions for patients* will be sent to the physician on request.

### references :

1. Journal-Lancet 70:298, 1950.
2. Rocky Mountain M. J. 48:99, 1951.
3. Am. J. M. Sc. 218:298, 1949.
4. J. M. Soc. New Jersey 48:12, 51.
5. Am. J. M. Sc. 219:139, 1950.
6. U. S. Armed Forces M. J. 1:332, 1950.
7. Circulation 1:502, 1950.
8. Cincinnati M. J. 31:137, 1950.
9. Southern M. J. 44:44, 1951.
10. M. Times 79:83, 1951.
11. J. A. M. A. 146:250, 1951.
12. Circulation 1:508, 1950.



# THIOMERIN<sup>®</sup>

## SODIUM

### MERCAPTOMERIN SODIUM WYETH

Council-Accepted Mercurial Diuretic for Subcutaneous, Intramuscular  
 or Intravenous Injection

*Wyeth* INCORPORATED, PHILADELPHIA 2, PA.



## GROWING INDUSTRIES FOR A GROWING COMMUNITY

# PORK PRODUCTION...



*Hawaii today is working to build new industries to aid in expanding the island economy. This series of advertisements calls attention to these forward steps . . . and to their promise for Hawaii's future.*



### ... these little pigs went to market

Captain James Cook, landing on Niihau on February 1, 1778, brought two big presents to the people waiting on the shoreline—a live boar and sow. He started a multi-million dollar industry.

Last year there were nearly 50,000 grown pigs on 560 farms in the Territory and piggery owners fell just a few pork chops short of producing three and a half million dollars worth of fresh meat for island dinner tables, an increase of nearly \$500,000 over 1950.

Pork production today is a growing industry. The number of both farms and pigs is increasing. Farmers are moving their piggeries from the city to rural areas where facilities for expansion are greater. And island pig breeders are steadily reducing the need of bringing live pigs from the mainland for local farms.

But pig producers and agricultural scientists see opportunities for further growth. More than a million and a half dollars in pork is still imported each year. Feed is imported in increasing quantities. Breeders are not yet able to supply all piggery needs. And adequate land for expansion is a major stumbling block.

Business and farm leaders, recognizing both the problems and the prospects, met in May to give both a hearing. In the Chamber of Commerce's fourth agricultural round table, a panel of speakers covered pork production from breeding and feeding to sales and serving, developing the steps necessary for expansion.

Today, with industry-wide cooperation, plus awakened interest in the islands' need for self-support, Hawaii can look for continued progress in this growing industry of a growing community.



*The development of new industries requires individual initiative and community cooperation. In keeping with this progressive spirit of growth, The Hawaiian Electric Co., Ltd., is constantly planning ahead, expanding its own facilities and equipment . . . building today for tomorrow's needs.*

**THE HAWAIIAN ELECTRIC CO., LTD.**



**BUILDING TODAY for Tomorrow's Needs**

## ONE KILLS EFFECTIVELY

Tomahawk antiseptics—that may simply stun bacteria or cause a lingering death—can not provide decisive germicidal action.

Zephiran chloride, a safe and well tolerated antiseptic, exerts a rapid and reliable bactericidal effect. It kills—does not merely stun—many gram-positive and gram-negative organisms. Zephiran chloride is a *refined* antiseptic; pharmacologic tests for tissue tolerance are made on each lot.

**Supplied as:**

Aqueous Solution 1:1000, bottles of 8 oz. and 1 U. S. gallon.  
Tincture 1:1000, tinted and stainless, bottles of 8 oz. and 1 U. S. gallon.  
Concentrated Aqueous Solution 12.8%, bottles of 4 oz. and 1 U. S. gallon (1 oz.=1 U. S. gallon 1:1000 solution). Must be diluted.

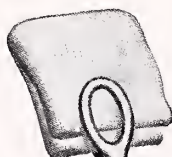
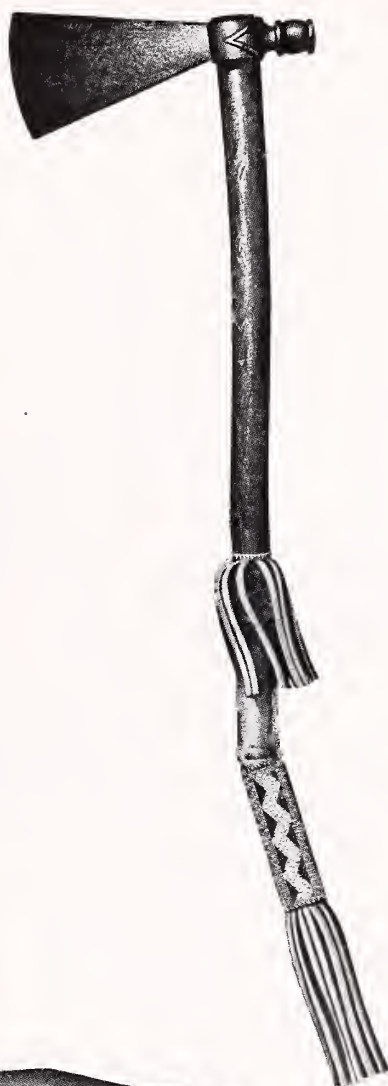
# ZEPHIRAN<sup>®</sup>

CHLORIDE

*for antiseptics with finesse...*

*Winthrop Stearns Inc.*

New York 18, N. Y. • Windsor, Ont.



Zephiran, trademark reg. U. S. & Canada, brand of benzalkonium chloride refined



**"PREMARIN"**®

Highly effective • Well tolerated • Imparts a feeling of well-being

**"PREMARIN"**

The menopausal patient  
welcomes the sense of well-being  
imparted by "Premarin."

**"PREMARIN"**

Estrogenic Substances (water-soluble)

**"PREMARIN"**



also known as Conjugated Estrogens (equine)

**"PREMARIN"**

5209



AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada



## How this Evaporating Plant Helps Protect Your Recommendation of Carnation

**IT'S THE CARNATION PLANT IN WAVERLY, IOWA.** And like *every one* of the many plants that process Carnation Milk, it is *Carnation-owned and Carnation-supervised.*

Yes, *all* milk sold under the Carnation label is processed by Carnation itself. Carnation never has and never will purchase milk packed by another company. This continuous cow-to-can control is further assurance that when you recommend Carnation, the baby will always get milk of the same uniformly high quality that has made Carnation a leading brand of milk in the world.

### Only Carnation gives Your Recommendation this 5-WAY PROTECTION

- 1. Carnation is constantly improving the raw milk supply.** Cattle bred from world champion Carnation bloodlines are shipped to dairy farmers all over the country to improve the milk supplied to Carnation evaporating plants.
- 2. Carnation accepts only high quality milk for processing.** Carnation Field Men regularly check local farmers' herds, sanitary conditions and equipment—reject milk if it fails to meet Carnation's high standards.
- 3. Carnation quality control continues even AFTER the milk leaves the plant.** To be sure of freshness and highest quality, Carnation salesmen use a special code control in making frequent inspection of dealers' stocks.
- 4. Carnation Milk is available everywhere.** Mothers can find Carnation Milk in virtually *every* grocery store in *every* town throughout America.
- 5. ALL the milk sold under the Carnation label is processed in Carnation's own plants such as the Waverly, Iowa, plant above.**



**DOUBLE-RICH** in the food values of whole milk.

**FORTIFIED** with 400 units of Vitamin D per pint.

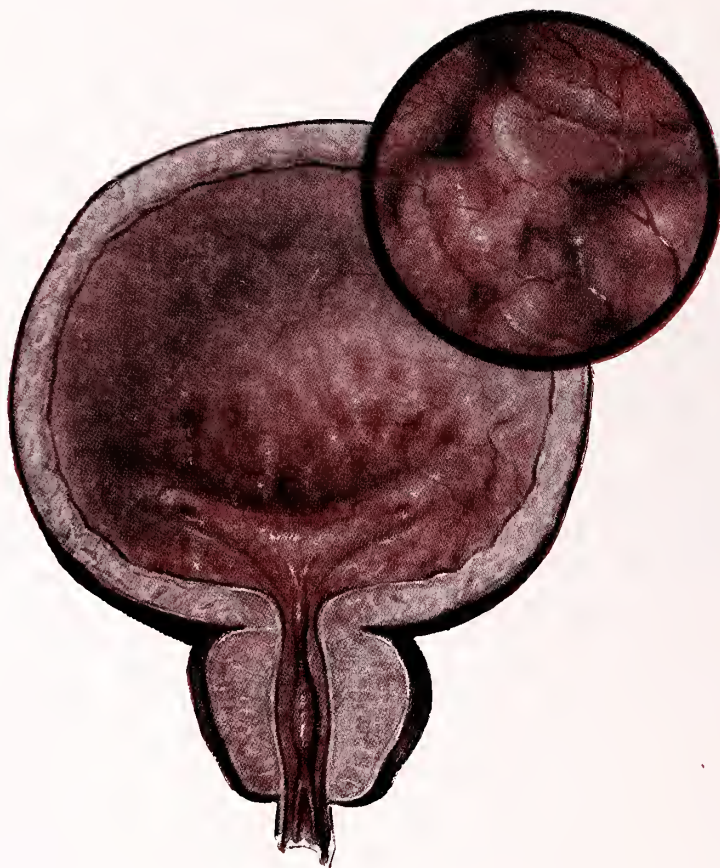
**HEAT-REFINED** for easier digestibility.

**STERILIZED** in the sealed can for complete safety.

**"The Milk Every Doctor Knows" "from Contented Cows"**







*in urinary tract infections:*

"Terramycin was selected [for 67 patients] in preference to other broad-spectrum antibiotics in view of high urinary excretion rate following small oral doses of the antibiotic." Post-operative pyuria was significantly reduced after 44 major gynecological operations, and various other genito-urinary complications responded equally well.

*Blahey, P. R.: Canad. M.A.J. 66:151 (Feb.) 1952*

ANTIBIOTIC DIVISION

*Pfizer*

mycin is also indicated in a wide range of

### GRAM-POSITIVE BACTERIAL INFECTIONS

*Lobar pneumonia • Mixed bacterial pneumonias*  
*Bacteremia and septicemia*  
*Acute follicular tonsillitis*  
*Septic sore throat • Pharyngitis*  
*Acute and chronic otitis media*  
*Acute bronchitis • Laryngotracheitis*  
*Tracheobronchitis • Sinusitis*  
*Chronic bronchiectasis*  
*Pulmonary infections associated*  
*with pancreatic insufficiency*  
*Scarlet fever • Urinary tract infections*  
*Acute and subacute purulent conjunctivitis*  
*Acute catarrhal conjunctivitis*  
*Chronic blepharoconjunctivitis*  
*not involving the meibomian gland*  
*Abscesses • Cellulitis*  
*Furunculosis • Impetigo*  
*Infections secondary to Acne vulgaris*  
*Erysipelas • Peritonitis*

### GRAM-NEGATIVE BACTERIAL INFECTIONS

*Gonorrhea • Brucellosis*  
*Bacteremia and septicemia*  
*Friedländer's pneumonia*  
*Mixed bacterial pneumonias*  
*Pertussis • Diffuse bronchopneumonia*  
*Post-partum endometritis • Granuloma inguinale*  
*Dysentery • Urinary tract infections*  
*Respiratory tract infections*  
*Cellulitis • Peritonitis • Tularemia*

### SPIROCHETAL INFECTIONS

*Syphilis • Yaws • Vincent's infection*

### RICKETTSIAL INFECTIONS

*Epidemic typhus • Murine typhus*  
*Scrub typhus • Rickettsialpox*  
*Q fever • Rocky Mountain spotted fever*

### VIRAL INFECTIONS

*Primary atypical pneumonia (virus pneumonia)*  
*Lymphogranuloma venereum • Trachoma*

### PROTOZOAL INFECTIONS

*Amebiasis*





## 8 to 24 hours of Allergy Relief

from a single dose of

### **DI-PARALENE<sup>®</sup> Hydrochloride**

(Chlorcyclizine Hydrochloride, Abbott)

ALLERGY patients like the convenience, effectiveness and economy of this longer-lasting antihistaminic. Published reports show that DI-PARALENE Hydrochloride—with a piperazine side chain rather than one of the conventional type—in many cases provides 24 hours of relief with a *single* dose.

Initially, DI-PARALENE should be administered in 50-mg. doses three times a day for the average adult, but in the majority of cases this can later be reduced to one or two doses a day. Side-effects are comparatively few and mild.

This season try longer-acting DI-PARALENE—available in 50-mg. and 25-mg. tablets, bottles of 100, 500 and 1000. **Abbott**

#### REFERENCES:

- Spielman, A. D. (1950), N.Y. St. J. Med., 50:2297, Oct. 1.
- Brawn, E. A., et al. (1950), Ann. Allergy, 8:32, Jan.-Feb.
- Jenkins, C. M. (1950), J. Nat. Med. Assn., 42:293, Sept.
- Cullick, L. and Ogden, H. (1950), South Med. J., 43:632, July.
- Ehrlich, N. J., and Kaplan, M. A. (1950) Ann. Allergy, 8:682, Sept.-Oct.

# Quick Urine-sugar Testing

**anyplace – anytime**  
with simple-to-use pocket set

## CLINITEST

(BRAND)

**C**LINITEST Urine-sugar Analysis Set contains all the elements needed for urine-sugar determination. The *Clinitest* Reagent Tablets, supplied with this Set, present a copper reduction test with all reagents compressed into a single tablet. The chemical principles involved are the same as those of the Benedict Test, *but no external heating is required*. Each tablet, in dissolving, generates the necessary heat.

*To perform a test*, simply drop one *Clinitest* Reagent Tablet into test tube containing proper amount of diluted urine. Allow time for reaction, then compare with color chart. Ideal for doctor or patient, *Clinitest* provides a rapid, convenient and reliable test for urine-sugar.

**Clinitest Urine-sugar Analysis Set No. 2106 (illustrated)**

Tablet refill available from your Chemist

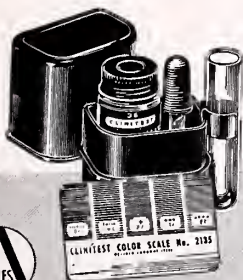
No. 2107 Bottle of 36

Literature available from our representative

**HOTEL IMPORT COMPANY**

P. O. BOX 2630

HONOLULU 3, HAWAII



**AMES COMPANY, INC.**  
Elkhart, Indiana, U. S. A.



Your ticket brings you travel,  
famous food, luxurious accom-  
modations...plus a wonderful  
vacation in the bargain

... it's all included in your fare on the

# LURLINE

AND  
round trip fares begin as low as

**\$260** (plus  
tax)

*Matson Lines*

1021 Bishop Street  
2347 Kalakave Ave.  
Phone 50945

or see any  
authorized  
travel agent

# Days

... spend a quiet hour in  
the library just relaxing ...  
meet your friends in  
the cardroom for  
bridge or canasta ...  
time out for lunch and  
a stroll in the open air ...  
an afternoon tea dance  
or a plunge in the pool.

Try your hand at  
shuffleboard and the  
other games on deck

There's day-long entertainment, a diversion for  
every hour... four days and five nights of gaiety  
and relaxation at a pace you set for yourself

# Nights

chat in the Smoking Room  
... there's a superb din-  
ner, an event in itself, in  
the dining room ...  
then a movie or a  
musical ... ship  
board sports to watch  
or enter, or a game of  
cards ... dancing in  
a night club at sea.

Listen to the music  
in the Outrigger Bar  
... have a sip and a

INDEX TO ADVERTISERS

	PAGE		PAGE
Abbott Laboratories .....	328	Merck & Co., Inc. ....	270
American Medical Education Foundation.....	310	Parke, Davis & Company.....	262, 263
Ames Company, Inc. ....	329	Pet Milk Company.....	272
Ayerst, McKenna & Harrison.....	324	Chas. Pfizer & Co., Inc. ....	326, 327
Borden Company .....	278	Philip Morris & Co., Ltd., Inc. ....	274
Carnation Company .....	325	Sandoz Pharmaceuticals .....	268
Convalescent Nursing Home .....	293	Schering Corporation .....	265
Dairymen's Association, Ltd. ....	275	Schieffelin & Co. ....	309
Don Baxter, Inc. ....	264	Schuman Carriage Company .....	276
Eli Lilly and Company.....	261, Insert	G. D. Searle & Co. ....	319
Ethicon Suture Laboratories, Inc. ....	Insert	Sharp & Dohme .....	269
Hawaiian Electric Company.....	322	Clinton D. Summers .....	320
Hawaiian Surgical Supply Company.....	266	Today's Health .....	309
Home Insurance Company.....	268	Upjohn Company .....	331
Hotel Import Company .....	271	Wander Company .....	267
Lederle Laboratories .....	273	Winthrop-Stearns, Inc. ....	323
Matson Lines .....	330	Wyeth Incorporated .....	321
Mead Johnson & Co. ....	332		

capacity to take in, esp. by suction; absorptive  
stance that absorbs. — **ab-sorb'en-cy**, *n.*  
**ab-sorb'ing** (-bing), *adj.* Engrossing. —

**ab-sorp'tion** (ăb-sôrp'shŭn), *n.*

[*L. absorptio.*] 1. Act or process of  
absorbing or of being absorbed; specif.

a Assimilation; as, the absorption of  
a smaller tribe. b The passage of di-

to absorb  
and  
be absorbed

*For efficient hemostasis* — When cut to  
shape and pressed against oozing capil-  
lary surfaces, Gelfoam promotes clot  
formation and actively *absorbs* up to  
45 times its weight in blood.

*For safe hemostasis* — When left *in situ*,  
Gelfoam is *absorbed* in 20 to 45 days  
with virtually no cellular reaction.

# Gelfoam\*



BRAND OF ABSORBABLE GELATIN SPONGE

Supplied in a variety of convenient sizes,  
including a sterile surgical sponge, den-  
tal pack, prostatectomy cone and biopsy  
sponge.

\*Trademark, Reg. U. S. Pat. Off.

a product of

**Upjohn**

**Research** for medicine . . . produced with care . . . designed for health

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN





A tradition in infant feeding for 20 years

*the quality and  
dependability of*

**PABLUM**

*cereals*

A multi-grain cereal and three single-grain cereals share the Pablum® heritage of quality.

Uniform texture, maximum digestibility and high nutritional values are assured by the careful Pablum processing.

Vitamins and minerals from natural sources are incorporated in Pablum Mixed Cereal, Pablum Oatmeal and Pablum Barley Cereal. Pablum Rice Cereal, with

crystalline vitamins, has special advantages of hypoallergenicity.

Recent improvements in Mead's exclusive manufacturing process bring out more than ever the rich, full grain flavors of all the Pablum cereals.

Older children as well as infants will like these 4 cereals and welcome the variety they provide.

You may prescribe Pablum cereals with confidence.



The Pablum packages, designed for superior protection and convenience, have the exclusive "Handy-Pour" spout.



**MEAD JOHNSON & CO.**  
EVANSVILLE 21, IND., U. S. A.

\*Registered Trademark

# HAWAII MEDICAL JOURNAL

and  
INTER-ISLAND NURSES' BULLETIN

JULY-AUGUST, 1952

THE N.Y. ACADEMY  
OF MEDICINE

NUMBER 6

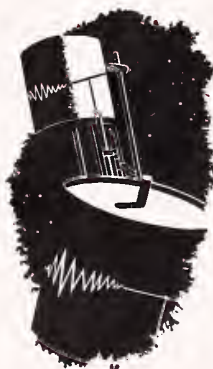
AUG 19 1952

LIBRARY

THE PATHOLOGY OF THE GROUND SUBSTANCE OF THE MESENCHYME William Boyd .....	353
THE INDISPENSABILITY OF STRESS Harry L. Arnold, Jr.....	358
POTASSIUM BROMATE POISONING DUE TO "COLD WAVE" NEUTRALIZER Walton M. Edwards and Charles L. Leedham.....	362
FEATURES .....	366
INTER-ISLAND NURSES' BULLETIN.....	397
INDEX TO VOLUME 11.....	404

*Proving ground*

*... in vivo*

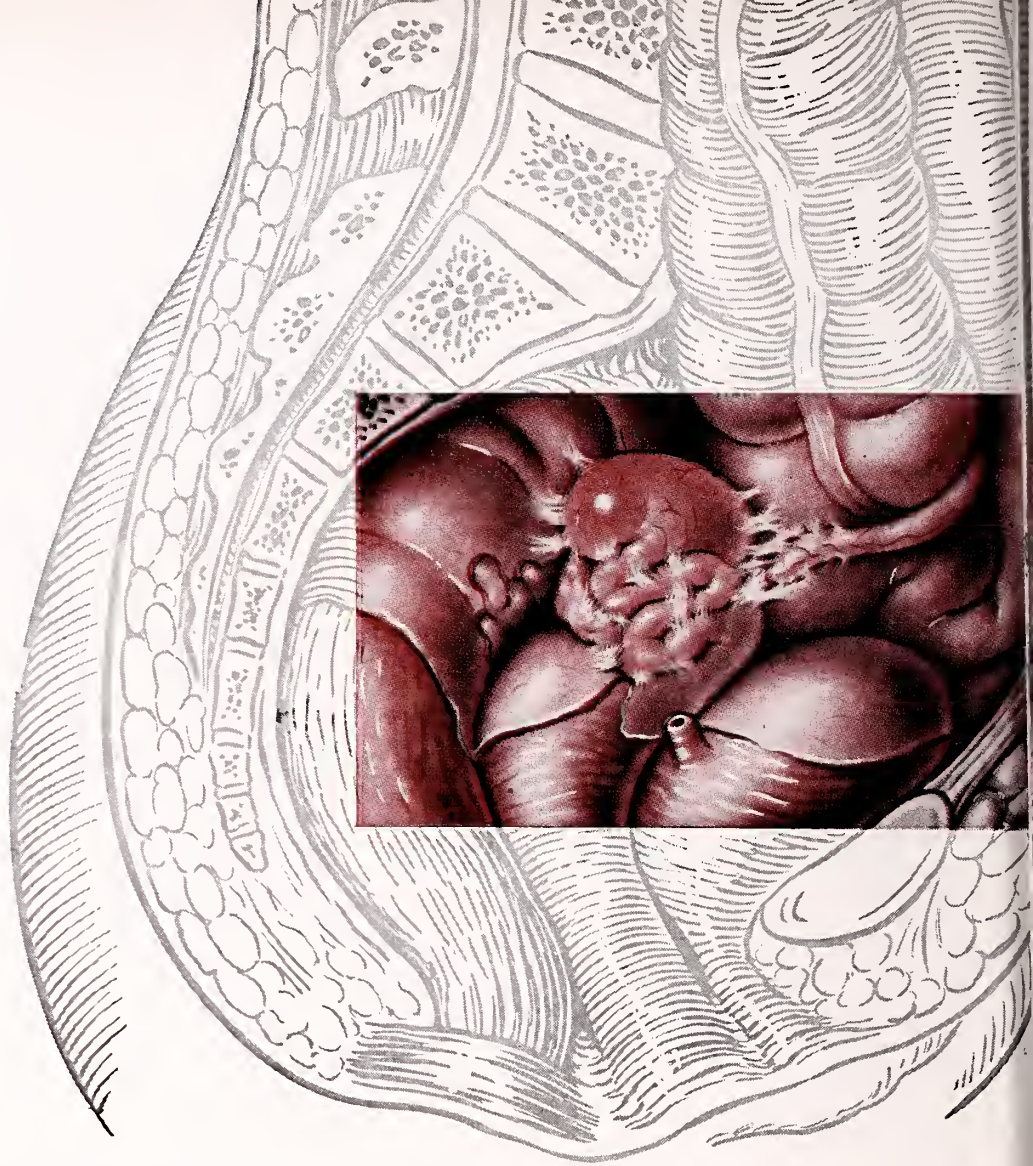


*Lilly*

Experimental pharmacology is the foundation of rational therapeutics. Through such experimentation, empiricism has been replaced by definite knowledge of how a given drug acts. The Division of Pharmacology of the Lilly Research Laboratories is equipped and staffed to study and evaluate new therapeutic agents.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.





***rapid response***

with **Chloromycetin<sup>®</sup>**

# *a pelvic inflammatory disease .....*

CHLOROMYCETIN produces prompt clinical response in the mixed infections commonly found in pelvic inflammatory disease. "In mixed infection [pelvic cellulitis and abscess]

CHLOROMYCETIN appears to be superior to penicillin, streptomycin or sulfadiazine."<sup>1</sup>

"The clinical response to chloramphenicol consisted of marked symptomatic improvement, usually within 48 hours. . . .

"Women who had large pelvic abscesses were treated so effectively with chloramphenicol that posterior colpotomy, with drainage of the abscess, was not necessary in effecting a rapid cure in any of our patients who were treated with this antibiotic from the start."<sup>2</sup>

**CHLOROMYCETIN** (chloramphenicol, Parke-Davis) is supplied in a variety of forms including:

**CHLOROMYCETIN** Kapseals®, 250 mg., bottles of 16 and 100.

**CHLOROMYCETIN** Capsules, 100 mg., bottles of 25 and 100.

**CHLOROMYCETIN** Capsules, 50 mg., bottles of 25 and 100.

**CHLOROMYCETIN** Ophthalmic Ointment, 1%, ½-ounce collapsible tubes.

**CHLOROMYCETIN** Ophthalmic, 25 mg. dry powder for solution, individual vials with droppers.

1. Greene, G. G.: Kentucky M. J. 50:8, 1952.

2. Stevenson, C. S., et al.: Am. J. Obst. & Gynec. 61:498, 1951.



*Parke, Davis & Company*  
DETROIT, MICHIGAN



# HAWAII MEDICAL JOURNAL

## and INTER-ISLAND NURSES' BULLETIN

Volume 11  
Number 6

JULY-AUGUST, 1952

\$2.00 per year  
35c per copy

Published Bi-Monthly by  
THE HAWAII TERRITORIAL MEDICAL ASSOCIATION  
(Incorporated in 1856 under the Monarchy)

Official Publication of:

Hawaii Territorial Medical Association  
Nurses' Association, Territory of Hawaii  
Hospital Association of Hawaii

Harry L. Arnold, Jr., M.D., *Editor*  
Mrs. Edith C. Bennett, *Managing Editor*  
Mabel L. Smyth Memorial Building  
510 S. Beretania St.  
Honolulu, Hawaii, U.S.A.

### THE HAWAII TERRITORIAL MEDICAL ASSOCIATION 1952-1953

#### OFFICERS

R. J. MCARTHUR, Wailuku, Maui.....	President
E. K. CHUNG-HOON, Honolulu.....	President-Elect
S. KASAMOTO, Hilo.....	Vice-President from Hawaii County
WILLIAM M. WALSH, Honolulu.....	Vice-President from Honolulu County
MARVIN BRENNECKE, Waimea.....	Vice-President from Kauai County
J. ALFRED BURDEN, Paia.....	Vice-President from Maui County
SAMUEL L. YEE, Honolulu.....	Secretary
THOMAS H. RICHERT, Honolulu.....	Treasurer

#### COMMITTEE CHAIRMEN

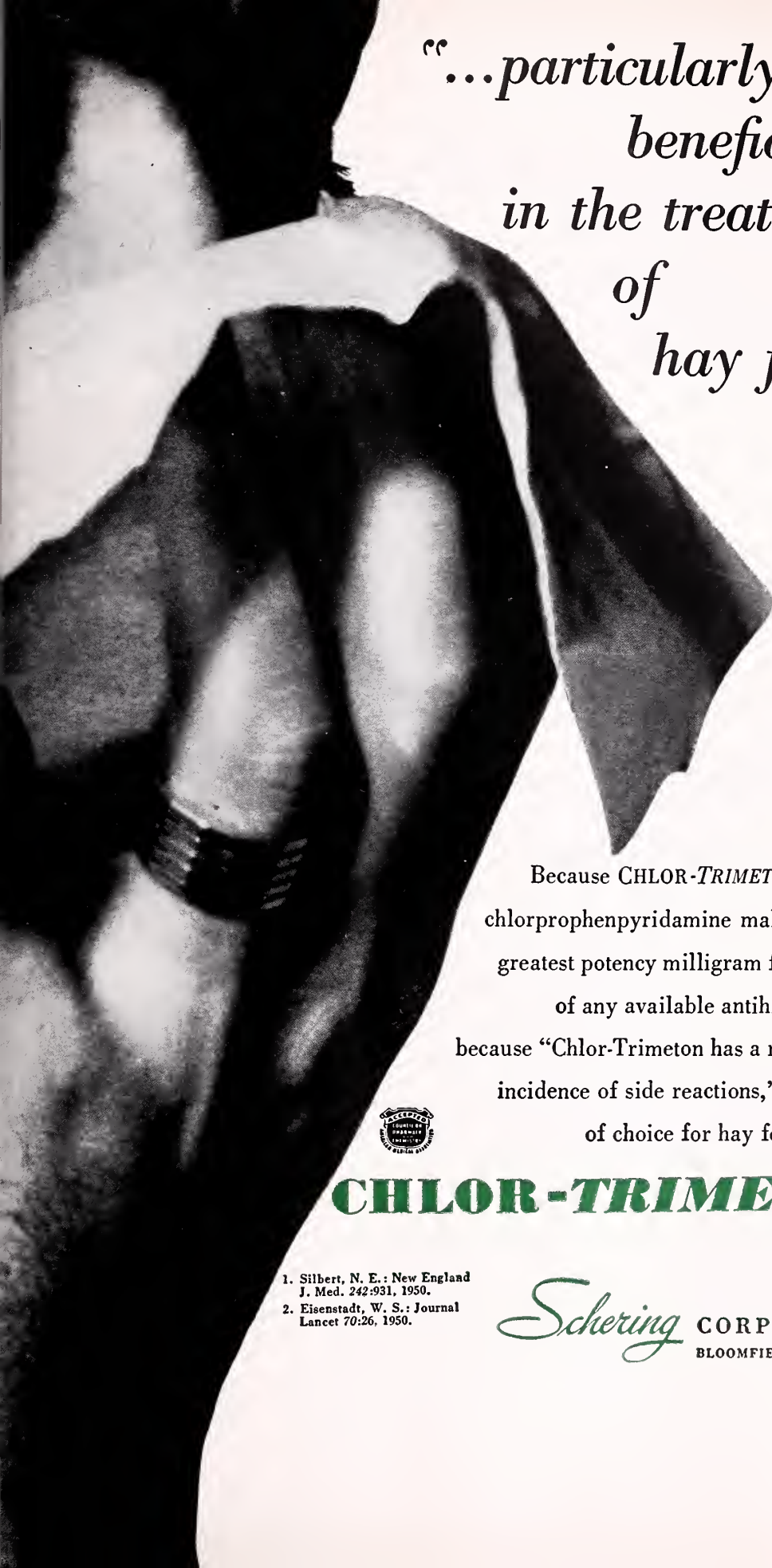
GROVER A. BATTEN.....	Cancer Committee
TELL NELSON.....	Health Education Committee
HARRY L. ARNOLD, JR., <i>Editor</i> .....	HAWAII MEDICAL JOURNAL
B. ALLEN RICHARDSON.....	Legislative Committee
MIN HIN LI.....	Medical Education Foundation
SAMUEL ALLISON.....	Public Service Committee
FRED I. GILBERT, JR.....	Scientific Works Committee
MORTON E. BERK.....	Diabetes Committee
JOHN BELL.....	Postgraduate Committee
WILLIAM WALSH.....	Advisory Committee for the Woman's Auxiliary
SHOYEI YAMAUCHI.....	Advisory Committee on Chronic Illness
J. WARREN WHITE.....	Advisory Committee on Crippled Children
DUKE CHO CHOY.....	Advisory Committee on Maternal and Child Health

#### OFFICERS — COUNTY SOCIETIES

	HAWAII	HONOLULU	KAUAI	MAUI
<i>President</i> .....	S. Kasamoto, Hilo	Wm. M. Walsh	Marvin Brennecke, Waimea	J. Alfred Burden, Paia
<i>Vice-President</i> .....	C. Hayashi, Kealahou	Wm. S. Ito	C. H. Ishii, Lihue	Harold Kushi, Kahului
<i>Secretary</i> .....	R. Yamanoha, Hilo	C. M. Burgess	Peter Kim, Kealia	Edmund Tompkins, Waiakoa
<i>Treasurer</i> .....	Kay Ota, Hilo	R. C. Durant	Peter Kim, Kealia	Edmund Tompkins, Waiakoa

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Pharmacy and Chemistry of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 15th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript, or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1952, by the Hawaii Territorial Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu 13, Hawaii.



*"...particularly  
beneficial  
in the treatment  
of  
hay fever."*<sup>1</sup>

Because CHLOR-TRIMETON<sup>®</sup> maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"<sup>2</sup> it is a drug of choice for hay fever patients.



## **CHLOR-TRIMETON**

**maleate**

1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26, 1950.

*Schering* CORPORATION  
BLOOMFIELD, NEW JERSEY

**CHLOR-TRIMETON**





# WHEN FOOD INTAKE *is inadequate*

When the patient's food intake is inadequate to supply essential nutrients in proper amounts, clinical experience has demonstrated the supportive value of a dietary supplement providing substantial quantities of virtually all needed nutrients—protein, vitamins, minerals, carbohydrate, and fat. The choice of the supplement prescribed, to a large extent, can determine the efficacy of the supplemented diet since over-all nutrient adequacy is the primary aim.

It is apparent from the data shown below that Ovaltine in milk can serve well in markedly increasing the intake of virtually all known nutrients. Taken daily during periods of inadequate consumption of other foods, it offers an excellent means for preventing subclinical nutritional deficiencies which can undermine general health or retard recovery from illness.

The appealing flavor of Ovaltine makes it acceptable to children as well as adults, including the aged. Ovaltine in milk is easily digested, an important feature when digestive disturbances are a factor.

Patients have the choice of either Plain or Chocolate Flavored Ovaltine, both of which are similar in their wealth of nutrients.

**THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.**

## Ovaltine

### Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

#### MINERALS

*CALCIUM.....	1.12 Gm.
CHLORINE.....	900 mg.
COBALT.....	0.006 mg.
*COPPER.....	0.7 mg.
FLUORINE.....	3.0 mg.
*IODINE.....	0.7 mg.
*IRON.....	12 mg.
MAGNESIUM.....	120 mg.
MANGANESE.....	0.4 mg.
*PHOSPHORUS.....	940 mg.
POTASSIUM.....	1300 mg.
SODIUM.....	560 mg.
ZINC.....	2.6 mg.

#### VITAMINS

*ASCORBIC ACID.....	37 mg.
BIOTIN.....	0.03 mg.
CHOLINE.....	200 mg.
FOLIC ACID.....	0.05 mg.
*NIACIN.....	6.7 mg.
PANTOTHENIC ACID.....	3.0 mg.
PYRIDOXINE.....	0.6 mg.
*RIBOFLAVIN.....	2.0 mg.
*THIAMINE.....	1.2 mg.
*VITAMIN A.....	3200 I.U.
VITAMIN B <sub>12</sub> .....	0.005 mg.
*VITAMIN D.....	420 I.U.

*PROTEIN (biologically complete).....	32 Gm.
*CARBOHYDRATE.....	65 Gm.
*FAT.....	30 Gm.

\*Nutrients for which daily dietary allowances are recommended by the National Research Council.

# Outstanding results with Furacin

Reasons for the clinical effectiveness of Furacin® include: a wide antibacterial spectrum, including many gram-negative and gram-positive organisms — effectiveness in the presence of wound exudates — lack of cytotoxicity: no interference with healing or phagocytosis — water-miscible vehicles which dissolve in exudates — low incidence of sensitization: less than 5% — ability to minimize malodor of infected lesions — stability.

Furacin preparations contain Furacin 0.2% brand of nitrofurazone N.N.R. dissolved in water-miscible vehicles.

for example:

## IN MALODOROUS LESIONS



The effective antibacterial action of Furacin can rapidly abate malodor. Such benefit has been reported in a variety of conditions: diabetic gangrene, varicose ulcers, chronic wounds, malignant lesions, otitis media.\*

\*Downing, J. G. et al.: J.A.M.A. 133:299, 1947. Shipley, E. R. et al.: Surg. Gynec. & Obst. 84:366, 1947. Wawro, N. W.: Connecticut M. J. 12:17, 1948. McCollough, N. C.: Indust. Med. 16:128, 1947. Long, P. H.: A-B-C's of Sulfonamide and Antibiotic Therapy, Philadelphia, W. B. Saunders, 1948, p. 152. Meyer, J. H.: J. Internat. Coll. Surg. 13:748, 1950.

Literature on request

**LABORATORIES Inc.**  
NORWICH, NEW YORK



The  
NITROFURANS



A unique class of  
antimicrobials

FURACIN SOLUBLE DRESSING • FURACIN SOLUTION • FURACIN ANHYDROUS EAR SOLUTION



# Still leading the family foursome

right through the menopause

ON ORAL ESTROGEN THERAPY  
THAT IMPARTS NO ODOR,  
NO TASTE, NO AFTERTASTE

**F**IRST, explain away her fears of the transition and assure her you can relieve her physical symptoms. Then, to prove your point, prescribe SULESTREX. Newest advance in the field, SULESTREX is as effective estrogen therapy as science has yet created. It is a pure estrone salt, stable and reproducible. There are no urinous ingredients to taint her breath or perspiration, even when therapy is intense, prolonged.

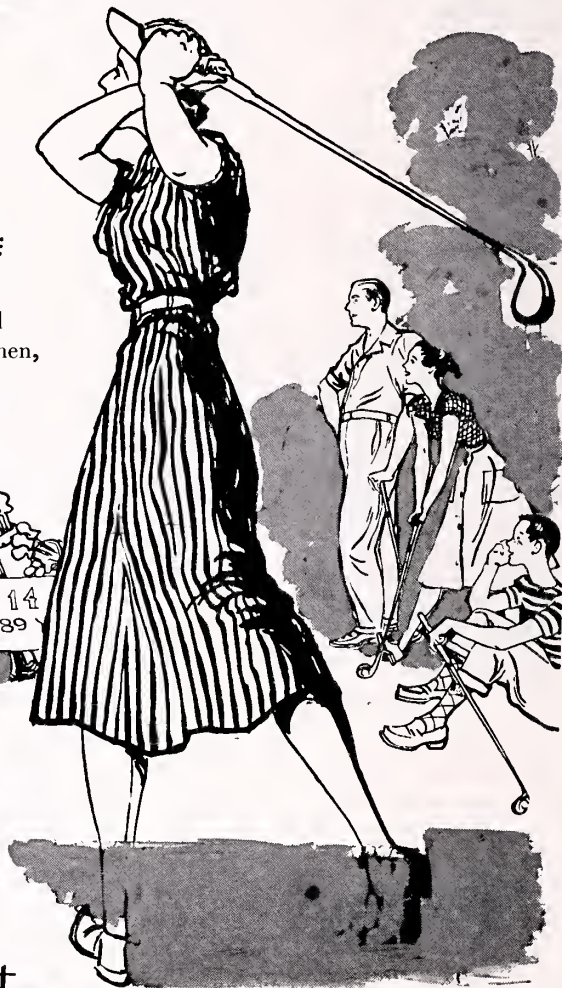
From two recent reports:

"... a potent and effective oral estrogen with an extremely low incidence of nausea."<sup>1</sup>

"... all patients noted a marked sense of well-being, and commented on their ability to resume normal activity with amazing vigor."<sup>2</sup>

Other studies have shown that you can expect constant, predictable results with SULESTREX with relatively few side-effects. Try this effective, esthetic therapy on your next menopausal patient. Available at all pharmacies in 0.75-, 1.5- and 3-mg. grooved tablets. Send for literature. Abbott Laboratories, North Chicago, Illinois.

**Abbott**



1. Perloff, Wm. H. (1951), *Treatment of the Menopause. II. American J. Obst. & Gynec.*, 61:670, March. 2. Reich, W. J., et al. (1951), *A Recent Advance in Estrogen Therapy. I. American J. Obst. & Gynec.*, 62:427, August.

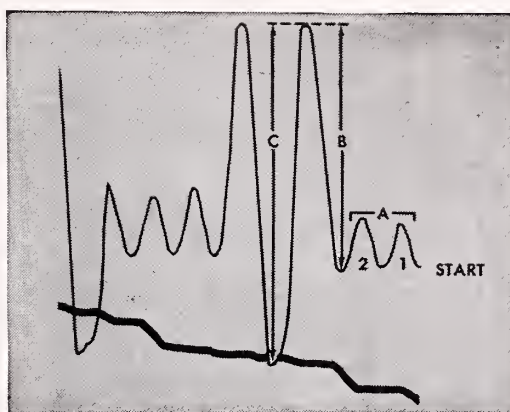
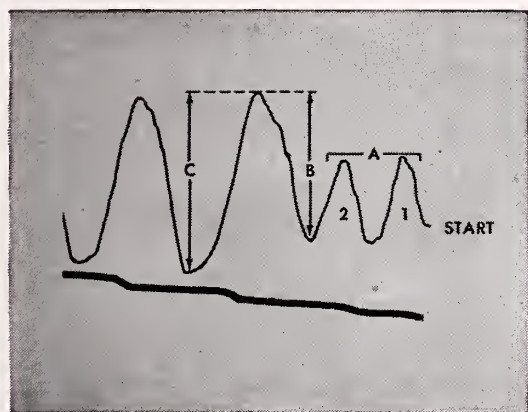
## Sulestrex

TRADE MARK

(PIPERAZINE ESTRONE SULFATE, ABBOTT)

Piperazine tablets

# *Cortone<sup>®</sup> provides striking benefit in intractable bronchial asthma...*



A. Tidal breathing    B. Complementary air    C. Vital capacity

Typical spirogram of asthmatic. Note marked diminution in vital capacity and complementary air; also, the over-all lengthening of the interval between inspiration and expiration.

This spirogram illustrates the improvement that may be expected in asthmatics following the administration of CORTONE. Note in particular the increase in vital capacity.

## Increased Vital Capacity—an objective measure of the effectiveness of CORTONE

**EFFECTIVE.** Intended as adjunctive therapy, "orally administered, cortisone definitely relieved the symptoms of chronic intractable asthma in 26 of 31 courses given to 22 patients."

for up to two weeks without extensive tests if there were proper cooperation between patient and physician and careful observation. . ."

Schwartz, E., *J.A.M.A.* 147: 1734-1737. Dec. 29, 1951.

**SIMPLIFIED MANAGEMENT.** "The patients' weight, fluid intake and output, blood pressure, and the results of the urine examination for sugar were charted daily . . . it was found that short-term therapy could be carried out safely

Literature  
available

# *Cortone<sup>®</sup>*

ACETATE  
(CORTISONE ACETATE, MERCK)

CORTONE is the registered trade-mark of  
Merck & Co., Inc. for its brand of cortisone.



**MERCK & CO., INC.**

*Manufacturing Chemists*

RAHWAY, NEW JERSEY  
In Canada: MERCK & CO. Limited - Montreal





# LOW BLOOD LEVEL HIGH EFFICIENCY

SULFASUXIDINE®, a virtually non-toxic intestinal bacteriostat, is a reliable—yet inexpensive—preparation for sterilizing the bowel preceding surgery.<sup>1</sup> Sparingly absorbed, approximately 95% of this efficient bacteriostatic agent remains concentrated in the intestinal tract. Consequently, blood levels

are negligible, and there is little possibility of systemic toxicity. Supplied as compressed tablets, 0.5 Gm., bottles of 100, 500, and 1,000; and as powder, in ¼-lb. and 1-lb. bottles.

Sharp & Dohme, Philadelphia 1, Pa.

1. Ault, G. W.: Southern M.J., 44:737, 1951.

**Sharp & Dohme**

# Sulfasuxidine

®

Succinylsulfathiazole Intestinal Bacteriostat

**THEO. H. DAVIES & CO., LTD., HONOLULU**

*Sole Distributor*



## How this Carnation Salesman Helps Protect Your Recommendation of Carnation

**THIS SALESMAN**, and hundreds like him throughout the country, do more than just *sell* Carnation Milk. At regular intervals they also *inspect* Carnation stocks already on the retailers' shelves. By checking a special code control number on every can, these salesmen insure fresh, quality milk for the consumer...and thus help to protect your recommendation of Carnation.

### Only Carnation Gives Your Recommendation This 5-WAY PROTECTION

1. Carnation is constantly improving the raw milk supply. Cattle from world champion Carnation bloodlines are shipped to dairy farmers all over the country to improve the milk supplied to Carnation evaporating plants.
2. Carnation accepts only high quality milk for processing. Carnation Field Men regularly check local farmers' herds, sanitary conditions and equipment — reject milk if it fails to meet Carnation's high standards.
3. Carnation processes ALL the milk sold under the Carnation label. From cow to can Carnation Milk is processed—with *prescription accuracy*—in Carnation's own plants under its own supervision.
4. Carnation Milk is available everywhere. Mothers can find Carnation Milk in virtually every grocery store in every town throughout America.
5. Carnation quality control continues even AFTER the milk leaves the plant, through frequent inspection of dealers' stocks by Carnation salesmen.

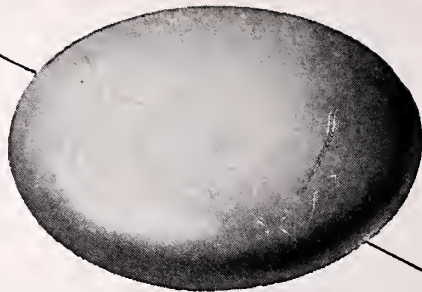
"The Milk Every Doctor Knows"



**DOUBLE-RICH** in the food values of whole milk  
**FORTIFIED** with 400 units of vitamin D per pint  
**HEAT-REFINED** for easier digestibility  
**STERILIZED** in the sealed can for complete safety

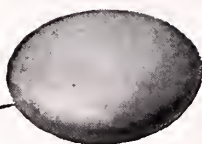
"from Contented Cows"





*new convenience*

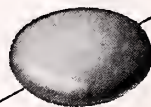
**in broad-spectrum therapy**



Easily swallowed, sugar-coated Terramycin  
Tablets introduce new flexibility in prolonged  
courses of administration and are particularly  
suited to effective, well tolerated therapy among  
patients preferring tablets to other oral forms.


*Supplied: 250 mg. tablets, bottles of 16 and 100;*

*100 mg. and 50 mg. tablets, bottles of 25 and 100.*



ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC.  
Brooklyn 6, N.Y.





CRYSTALLINE  
**Terramycin**  
AMPHOTERIC

SUGAR-COATED

tablets

WORLD'S LARGEST PRODUCER OF ANTIBIOTICS





Doctor,  
be your own  
judge...  
try this  
simple test

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke —and s-l-o-w-l-y let the smoke come *directly* through your nose.
2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between

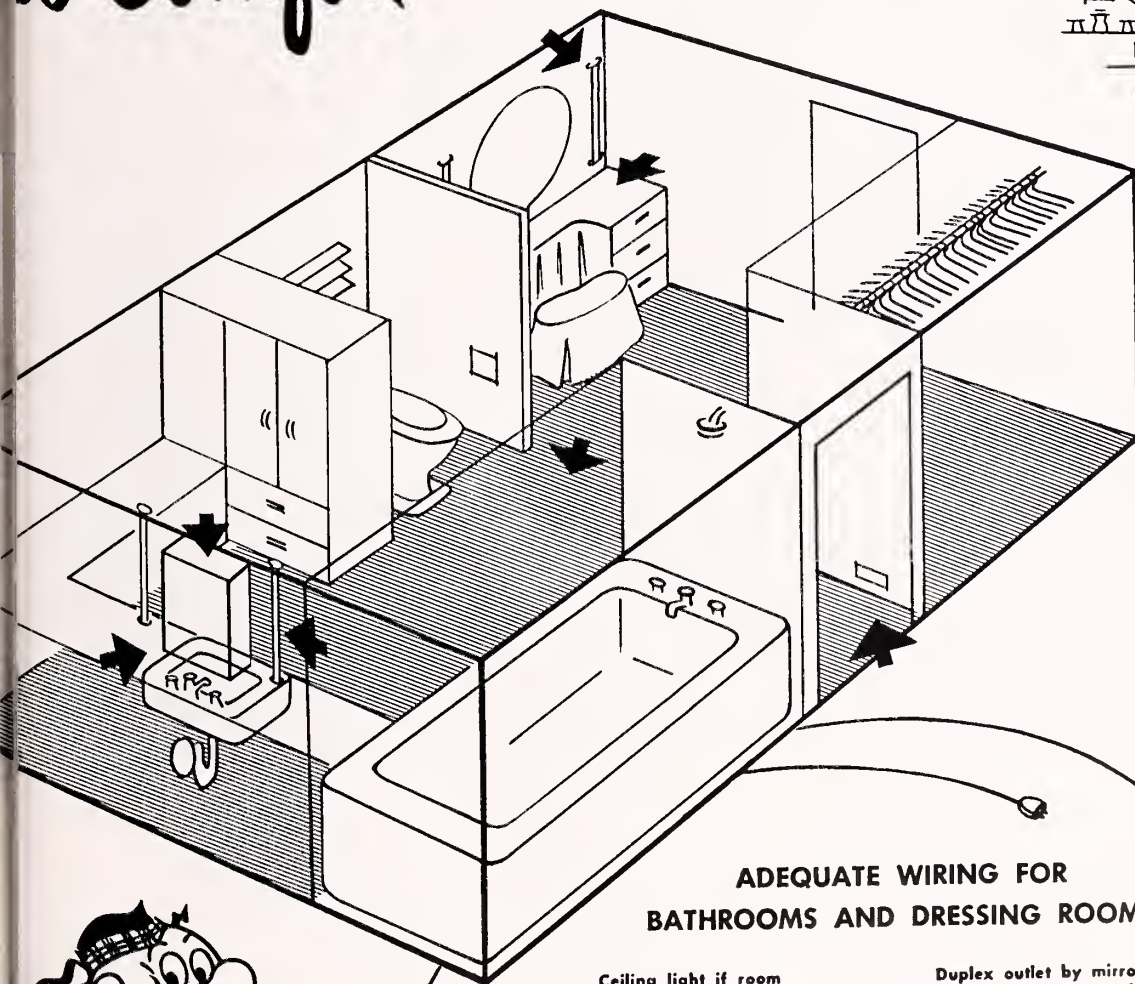
PHILIP MORRIS and any other leading brand.

**PHILIP MORRIS**

Philip Morris & Co. Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

# You Can Switch to Comfort

You'll save many a stumble on a slick floor just by putting some light on the problem. You'll save plenty of both work and time just by putting electrical appliances on the job. In either case you need adequate electric wiring. When your home's wired right, help is always close at hand, ready when you flick a switch.



## ADEQUATE WIRING FOR BATHROOMS AND DRESSING ROOMS

- ✓ Ceiling light if room is 60 sq. ft. or more; can be recessed fixture
- ✓ Vaporproof fixture over shower or tub, controlled by outside wall switch
- ✓ Wall light on each side of mirror for even light; fluorescent if desired
- ✓ Duplex outlet by mirror, 3 to 4 ft. from floor, for shaver, hair dryer, etc.
- ✓ Automatic light on medicine cabinet door for safety
- ✓ Night light near floor to prevent accidents; can be controlled by wall switch
- ✓ Duplex outlets each end of dressing table for lamps

### FREE ADVISORY SERVICE

Got a question about wiring or lighting? Need individual help with your home? Call Miss Margaret Jean Bolte, Hawaiian Electric's home lighting specialist . . . it's free!

# THE HAWAIIAN ELECTRIC CO., LTD.

Your home-owned electric utility • Bringing you better living — electrically.



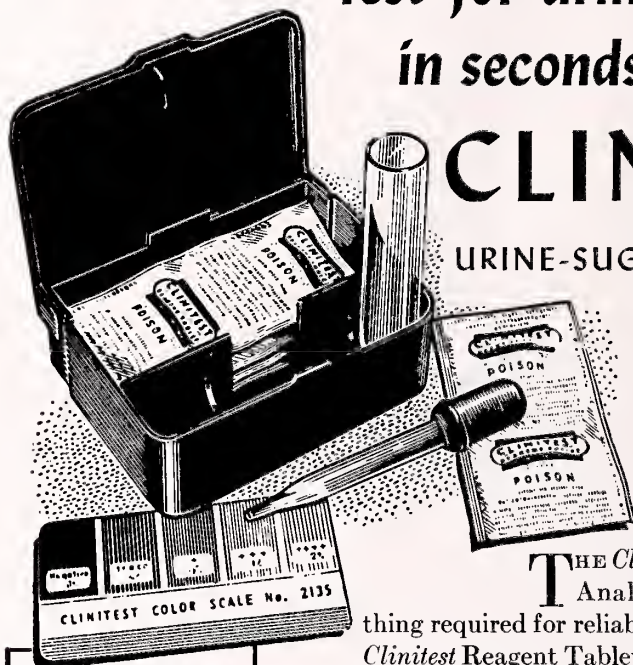
Test for urine-sugar  
in seconds...with New

# CLINITEST

(BRAND)

URINE-SUGAR ANALYSIS TEST

UNIVERSAL  
MODEL



**T**HE *Clinitest* (Brand) Urine-sugar Analysis Set contains everything required for reliable urine-sugar testing. The *Clinitest* Reagent Tablets (Sealed in Foil), supplied with this Set, present a copper reduction test with all reagents compressed into a single tablet. *No external heating is required* as each tablet, on dissolving, generates the necessary heat.

To perform a test, simply drop one *Clinitest* Reagent Tablet into test tube containing proper amount of diluted urine. Allow time for reaction, then compare with color scale. A rapid, convenient and reliable test for urine-sugar that is ideal for doctor, patient and laboratory.

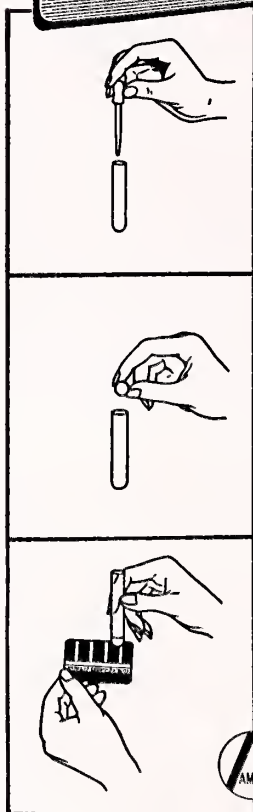
Each Set contains 10 *Clinitest* Reagent Tablets individually sealed in foil. Tablets may be replaced with either additional tablets sealed in foil from No. 2157, boxes of 24, or with No. 2107 bottles of 36. Contact our representative for literature.

**HOTEL IMPORT COMPANY**

P. O. BOX 2630

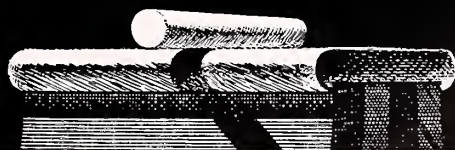
HONOLULU 3, HAWAII

**AMES COMPANY, INC.**  
Elkhart, Indiana, U. S. A.



No other bulk container  
for intravenous therapy  
is as safe as

VACOLITER<sup>®</sup>

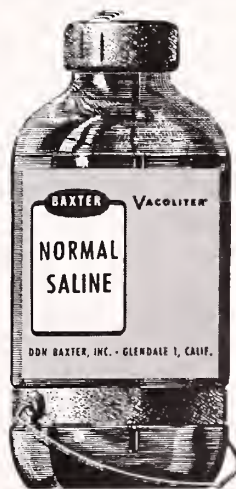


For Greater Patient Protection...

**BAXTER**

Specialists in Parenteral Therapy for Over 20 Years

**VACOLITER<sup>®</sup>**



DON BAXTER, INC. • RESEARCH AND PRODUCTION LABORATORIES • GLENDALE 1, CALIFORNIA

Territorial Distributor:

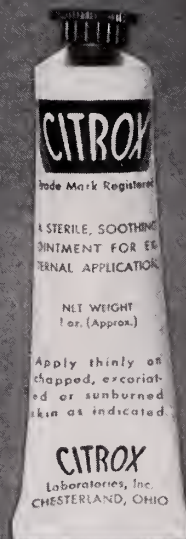
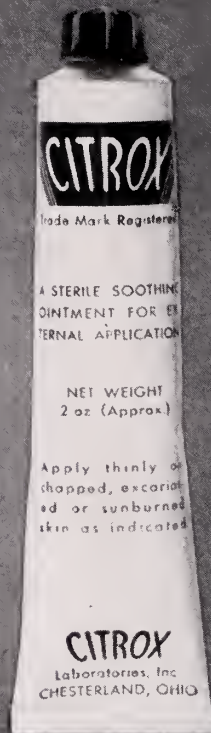
**CROCKETT SALES COMPANY**

P. O. Box 3017 • Honolulu, T. H. • Phone 6-8992



FOR USE BY THE MEDICAL PROFESSION

A proven mild, sterile, greaseless ointment compounded with extreme care from U.S.P. ingredients for cases of local irritation to the dermis and epidermis.



*Citrox contains: lanolin, glycerin, sodium benzoate, stearic acid and oil of lemon in a neutral oleaginous base.*

Because Citrox is bacteriostatic to staphylococcus aureus it may be safely used in maternity work without additional sterilization. It has been found in hospital checks to be very effective for sore and fissured nipples, as a conditioner on breasts and for excoriated buttocks on infants.

It is also used extensively for chapped,

chafed, windburned or sunburned skin, for irritation and excoriation around the nasal passages, pruritus vulvae et ani and other forms of pruritus, reactions from x-ray therapy, prevention of "mercury rash" in control of infant impetigo, irritations of epidermis caused by confinement in bed and for certain types of industrial dermatitis.

ANOTHER FINE PRODUCT FROM  
**HAWAIIAN SURGICAL SUPPLY COMPANY**

A DIVISION OF  
**HAWAIIAN GAS PRODUCTS, LIMITED**

**"PREMARIN"**®

Highly effective • Well tolerated • Imparts a feeling of well-being

**"PREMARIN"**

Thousands of physicians  
prefer "Premarin" for the  
treatment of the menopause.

**"PREMARIN"**

Estrogenic Substances (water-soluble)

**"PREMARIN"**



also known as Conjugated Estrogens (equine)

**"PREMARIN"**

\$210



AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada





# Rx "Prescription for Good Growth"

For proper body growth and tissue development, it is imperative that infants have ample protein in the early months of life.

With DRYCO, you have an ideal infant food to recommend—a food that meets special protein demands and, in fact, closely approximates the other nutritional and digestional advantages of breast milk.

DRYCO has a 2.7 to 1 ratio of protein to fat. Thus it compensates for the biological differences between cow's milk and human milk proteins to give infants an adequate supply of this "priority" food element. An additional feature of DRYCO's lower fat content is the fact that vomiting, indigestion and constipation often caused by excessive fat are reduced.

To ensure best nutrition, DRYCO has been fortified with vitamins A and D. All DRYCO formulas supply adequate amounts of vitamins A, B<sub>1</sub>, B<sub>2</sub>, and D for the normal infant.

The moderate amount of carbohydrate in DRYCO permits the addition of the amount and type of carbohydrate required by each case. DRYCO is easy to prepare... the mother simply dissolves DRYCO in cool, previously boiled water to which carbohydrate has been added. In every sense then, it is an ideal infant food.

Remember, DRYCO provides ideal nutrition for the normal infant. That makes it an excellent product for you to recommend.

VITAMIN FORTIFIED  
**DRYCO**



Copy. 1951  
Borden Co. Prop.  
Intellectual Res.

44T



More data available on request to:

THE BORDEN COMPANY, Export Division  
350 Madison Avenue, New York 17, N. Y., U.S.A.



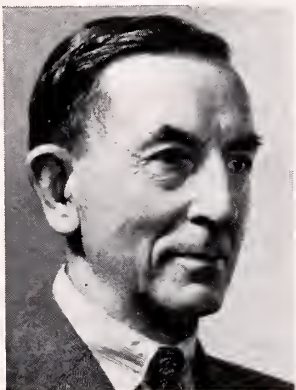
# The Pathology of the Ground Substance of the Mesenchyme

WILLIAM BOYD, M.D.\*

VANCOUVER, CANADA

**M**ODERN MEDICINE and modern pathology are based on the idea of specificity, but undue obsession with this idea has served to overshadow the value of general pathology as a guide in thinking. The subject of our discussion today may serve to direct our attention to this more general concept.

The body is composed of cells and fibres, just as a house is composed of bricks or stones and wood. But if a house consisted of nothing else, if it were lacking in cement and glue and nails, it would be like a house of cards. A well-built house *can* be pushed over, but only by a great force like an earthquake, or a bomb, whereas a house of cards will fall at a touch. So it is with the house of the body. The cement and ground substance hold the constituent parts together, but they also perform equally important functions.



DR. BOYD

## The Ground Substance

It was in 1876 that Flemming first described a cementing substance which binds the fibrils of connective tissue into bundles of fibres. In the past, however, the ground substance has been supposed rather than studied, and has been denied a personality of its own. Our modern interest in the subject dates from the work of Sylvia Bensley in 1934. The difficulty of studying the substance in fresh connective tissue is the fact that its refractive index is similar to that of water, and when unfixed it is soluble in water. Bensley used blood serum, which does not dissolve the ground substance, to produce blebs of the skin in animals. Into a bleb she introduced a culture of paramecia and watched their behaviour under the microscope. They were seen to swim about very actively, but they would suddenly rebound without coming into contact with any visible structure. They behaved in the same way when in contact with

gelatin. It became evident that some material separated the cells and fibres.

This ubiquitous material is not a mere glue or filler-in. It may be non-living, but it is not inert. Through it has to pass the nutriment from capillaries to parenchymatous cells, and metabolites passing in the reverse direction. Interference with this transport seems to lead to depression of cellular respiration, with, it may be, necrosis and ultimate sclerosis. It is in the ground substance that the inflammatory process takes place, and this all-embracing material seems to be the site of antigen-antibody reaction. Indeed, it is not too much to say that the concept of a cell is not complete without a consideration of its ground substance.

In 1936 Meyer, who was studying the vitreous humor in connection with the mechanism responsible for the production of glaucoma, reported the occurrence in the vitreous of an acid mucopolysaccharide of high molecular weight. As it contained glucuronic acid he called the substance hyaluronic acid, from its occurrence in the hyaloid or vitreous. Later it was demonstrated in Wharton's jelly, synovial fluid, and other sites. It is this material which forms the ground substance. A mucopolysaccharide is a protein-carbohydrate complex. A delicate balance exists between the protein and the carbohydrate, either one being removable by enzyme action. If this balance is upset, the ground substance suffers, and what we call "degeneration" is the result. Disturbance in the balance of the ground substance is probably an essential feature not only of fibrinoid necrosis, but also of amyloid and hyaline degeneration, the Kimmelstiel-Wilson glomerular lesion, and the change in hypertensive arteritis.

The hyaluronic acid may become sulphated, thereby acquiring increased consistence. As the sulphated form is most abundant in cartilage, the material is known as chondroitin sulphuric acid, a principal constituent of amyloid. The sulphated form is markedly metachromatic with certain basic dyes such as toluidin blue which combine with the acid radicle.

The ground substance has gel-like structure by virtue of its long-chain polymers, which render it highly viscous. When depolymerization occurs the linkage of the polymers is broken, the viscosity

Read before the Sixty-second annual meeting of the Hawaii Territorial Medical Association, Honolulu, May 3, 1952.

\* Professor of Pathology and Bacteriology, University of British Columbia.



reduced, and permeability is therefore increased. At the same time metachromasia is lost. It will be evident that the permeability of tissue, so important both in health and disease, is a physical quality determined by the amount and consistence of the ground substance. The permeability is low in epithelium in which the ground substance is minimal, and high in subcutaneous tissue in which it is abundant. There are therefore wide variations in the permeability of different tissues, and even in the same tissue in different regions. Factors such as age, sex, hormone activity, and especially the sex hormones and vitamin C, modify the degree of permeability.

The physical nature of the bodily structures also depends largely on the nature of the mucopolysaccharides of the ground substance. Thus the viscosity of synovial fluid, the high flexibility of the intervertebral discs, the turgor of the nucleus pulposus, and the transparency of the vitreous are dependent on the presence of hyaluronic acid, whilst the rigidity of cartilage is due to chondroitin sulphuric acid.

The proportion of amorphous ground substance to formed fibrous elements varies greatly in different sites. Thus tendon is almost all fibres, whereas Wharton's jelly is almost pure mucopolysaccharide. Embryonic connective tissue is largely amorphous, adult connective tissue mainly fibrous. A series of steps can be traced both in the development from the embryo to the adult and in the evolution of the granulation tissue of inflammation into fully formed collagen. First there is fluid ground substance which develops into a gel, then argyrophilic reticular fibres, and finally dense collagen.

The ground substance is probably produced by fibroblasts. This process is influenced in some sites by sex hormones. Bensley has traced the formation of ground substance in the changes which the endometrial stroma undergoes in the menstrual cycle. Metachromasia is marked during the proliferative phase, but gradually this is completely lost. Even the ordinary connective tissue is under hormonal influence. Removal of the gonads or adrenals results in great fibrosis in areolar connective tissue, the collagenous fibrous tissue increasing to 10 times the normal. The administration of estrogen results in a return to normal.

### Hyaluronidase

Let us now turn to the other side of the picture and consider the factors which may influence the state of the ground substance. An enzyme, hy-

aluronidase, which acts on this substrate, was first obtained in 1936 from the capsules of Group 1 mucoid hemolytic streptococci. It is now known to be identical with the spreading factor demonstrated in 1928 by Duran-Reynals while observing the effect of testicular extract on the spread of vaccinia virus in the tissues. The permeability of the skin is increased, as a result of which coloured solutions or India ink diffuse through the skin like fluid dropped on a blotter. At first this observation was of purely academic interest, but with the discovery of the factor in pathogenic bacteria, snake venom, leeches, poisonous insects, bee stings, spermatozoa, and certain vigorously growing malignant tumors, it soon became evident that it was also of great practical importance. It will be seen that there are two groups of spreading factors, those derived from tissues and those derived from bacteria. The enzymes depolymerize the hyaluronic acid molecule, splitting the linkage of the polymers, and thus altering the physical consistence of the ground substance so that it no longer presents a barrier to the passage of material through it. In the depolymerized state the components of the ground substance may become water-soluble and removable into the general circulation. At the same time the property of metachromasia is lost.

It must not be thought that the matter is as simple as may appear from the above account. The metachromatic substances of normal tissues show a varying solubility in hyaluronidase. Moreover there is every reason to believe that there is more than one enzyme, and that the enzymes may act differently on different substrates. Thus testicular extract destroys the metachromatic staining of ground substance, whereas leech-head extract does not. Only hyaluronidase of testicular origin will hydrolyze chondroitin sulphuric acid; the streptococcal enzyme will not, acting only on hyaluronic acid. The testicle itself produces at least two enzymes which act on different substrates.

The reaction of enzyme on substrate is affected by conditioning factors of extraordinary subtlety and diversity. Of these the most dramatic is cortisone. Its anti-arthritic activity is known to everyone. When injected together with the testicular spreading factor it prevents the spread of a drop of India ink. Other steroids, particularly the sex hormones, also influence the interplay of enzyme and substrate. This is of particular interest in view of the striking sex incidence of some of the collagen diseases, disseminated lupus in particular.

It becomes evident that the state of the ground substance depends on a delicate balance between

enzyme and substrate. The enzymes necessary to maintain this balance may exist in the mesenchymal cells. If the substrate is increased, the consistence of the ground substance becomes more gel-like, and the spread of particulate matter is diminished. When the reverse takes place the spread is facilitated. Permeability has a normal state or tonus, but this can increase or decrease. There is evidence to support the belief that anti-spreading antibodies may be produced. These would automatically restrict the permeability.

The application of these ideas to the problem of bacterial invasion gives food for thought. If bacteria of low virulence are unable to spread in the skin owing to an increase in the gel-like state at adolescence they may multiply locally and give rise to the lesions of acne. Bacteria such as hemolytic streptococci and *Cl. welchii* which produce much hyaluronidase might be expected to spread widely, as indeed they do.

The engaging idea that streptococcal hyaluronidase may directly cause connective tissue destruction in the rheumatic diseases unfortunately appears to be untenable. But the capsule of streptococci contains hyaluronic acid, and this may stimulate the tissues themselves to produce too much enzyme, which may in turn act on the ground substance. The only germs known to produce hyaluronic acid are groups A and C hemolytic streptococci in the mucoid phase, whereas many non-mucoid hemolytic streptococci may produce hyaluronidase.

Hyaluronic acid is the first obstacle to be overcome by the invader. Likewise hyaluronidase seems to be the first weapon used against the host by those bacteria which produce it. The degree of invasiveness appears to be directly related to the amount of enzyme produced. This, however, must not be confused with virulence. Highly virulent bacteria often produce only mild local skin lesions.

Hyaluronidase is antigenic, so that anti-spreading antibodies may be produced and can be demonstrated in the blood. There are thus three factors to be considered: the substrate, the enzyme, and the enzyme inhibitor. The antibodies are strictly specific for the source of the enzyme. Thus anti-serum against bull testicle enzyme does not act against mouse testicle enzyme, and the same is true of the hyaluronidase produced by different bacteria. Hyaluronic acid on the other hand, is non-antigenic and fails to play a part in immune reactions, so that bacteria containing it in their covering are given temporary protection against the humoral defences of the body.

From this brief outline it will be realized how difficult it is to apply the new knowledge regard-

ing the ground substance and spreading factors to the practical problems of bacterial infection.

The same is true of the relationship of mucolytic enzymes to invasiveness in carcinoma. It has been suggested that secretion of these enzymes is a normal property of undifferentiated epithelium, but this is lost in differentiation to the adult state. When hyaluronidase is injected into a transplantable mouse carcinoma the rate of growth is greater than in the controls. There is extensive invasion of the ribs and abdomen, which is lacking in control animals. There is more evidence in support of a spreading factor in carcinoma than sarcoma, but there are still so many discrepancies in the work that conclusions are not justified.

The viscid contents of bursae and ganglia consist largely of mucopolysaccharides, and the pathogenesis of these lesions may be related to the action of hyaluronidase.

There appears to be a continual production of hyaluronidase in the eye, and an equally constant removal. This is probably related to the maintenance of the normal tension of the eyeball. There is reason to believe that the secret of glaucoma lies in a loss of the normal equilibrium between enzyme and substrate.

Ground substance is an important constituent of the walls of blood vessels, and changes in the mucopolysaccharides may play a part in the ageing and hardening of the arteries.

In Graves' disease the hyaluronic acid gel is decreased in amount, and the skin becomes thinner. In myxedema, on the other hand, the gel is increased and the skin is thickened. This suggests strongly that the thyroid hormone controls the balance of enzyme and substrate.

The envelope of follicular cells which surrounds the ovum is removed by the hyaluronidase carried by the numerous sperms which accumulate in the neighbourhood. This permits the penetration of one spermatozoon into the ovum. As the ova of birds, amphibia and reptiles have no covering of follicular cells, it is not surprising to learn that the testes of these animals do not produce hyaluronidase. Sterility in this case can therefore not be blamed on male lack of enzyme.

Hyaluronidase may even enter into the problem of urinary calculi. These calculi become fragmented in a test tube when treated with the enzyme, which acts on the polysaccharides, chondroitin sulphate and mucin, of the binding matrix.

This cursory survey will serve to indicate that the subject of the interaction of enzymes on mucopolysaccharides is much wider than the field of the collagen diseases.



### Fibrinoid

A new word has appeared in our vocabulary, a mystic word, fibrinoid. But there is nothing new under the sun. It was in 1880 that Newmann coined the term, and German workers wrote exhaustively and exhaustingly on the subject. Modern enthusiasm for the subject dates from the observation of Klinge in 1933 that the primary and fundamental lesion of rheumatic fever is fibrinoid degeneration.

Fibrinoid is "a homogeneous, eosinophilic, relatively acellular refractile substance with some of the tinctorial properties of fibrin" (Altshuler and Angevine). In H. and E. sections it looks like fibrin, but with phosphotungstic acid hematoxylin it is said by Altshuler and Angevine to give a yellow to orange colour, whereas fibrin is stained blue. This has not been my own experience, and I do not believe that fibrinoid can be distinguished from fibrin by any staining methods at our command. Confusion occurs, owing to the fact that the two substances may occur together, as in periarteritis nodosa. The rheumatic nodule gives a reaction for pure fibrinoid without any admixture of fibrin. With trichrome fibrinoid stains bright red, in striking contrast to the blue or green of collagen. Schiff's reagent for aldehyde after treatment with periodic acid invariably gives a brilliant red, but it also stains fibrin, hyalin, and a great variety of materials other than aldehydes. Fibrinoid is metachromatic with toluidin blue in the initial stages, but when frank necrosis develops it loses this property. Metachromasia is in no sense specific for fibrinoid.

There is a tendency to assume that these various staining methods throw light on the chemical constitution of fibrinoid. This is not so. Fibrinoid is a physical rather than a chemical state, and the so-called histo-chemical methods are in reality indicators of physical, not chemical, condition.

There are various theories as to its formation. My own feeling is that the essence of the condition is a change in the amount and the physical state of the ground substance. This appears to be brought about by the co-precipitation of an alkaline protein and the acid mucopolysaccharide of the ground substance. The reaction seems to represent a change in the local metabolism which may be due to a shift in the pH. Whilst its main interest to us as pathologists lies in the striking role which it plays in the collagen diseases, it is important to bear in mind that it may be produced experimentally in a variety of ways. It is therefore wrong to say that it is an invariable indicator of an allergic reaction. In man it is seen in the base of a

peptic ulcer, in malignant arteriolonecrosis, in burns, and in other types of lesions.

The sequence of events is as follows. As the result of "injury" of various kinds a change takes place in the ground and cement substance marked by the development of a mucinous edema due to an accumulation of acid mucopolysaccharides which give metachromatic staining with toluidin blue. True fibrinoid material then develops in the metachromic area. Finally, as the result of these changes and of interference with the exchange of nutrient materials and the elimination of catabolites the collagen fibres swell and disintegrate and frank cellular necrosis develops.

*Pari passu* with these changes a cellular reaction develops, which may be either exudative or proliferative and granulomatous in character. In periarteritis nodosa there is an acute outpouring of polymorphonuclears and eosinophils, whilst in rheumatoid arthritis there is a proliferation of mesenchymal cells such as histiocytes and fibroblasts. In time the fibroblasts will convert the abundant ground substance into collagen, which may become dense.

### Collagen Disease

It is not my purpose to describe in detail the lesions of the group of conditions known as the collagen diseases. This has already been done by Duff, Klemperer and others, and the general features are known to all pathologists.

There are characteristics which they have in common, fibrinoid necrosis in particular. But the localization of the injury and the reaction of the tissues varies so much that we must guard against the temptation of assuming that the etiology and mode of production is the same in all. As Duff puts it so well: "Morphological resemblances and even the occurrence of certain practically identical lesions in the different diseases of the group cannot establish the theory of common pathogenesis."

The location of the target organ, and its state as determined by conditioning factors, are of prime importance. If the injury is confined to the ground substance of the small muscular arteries, the lesions are those of periarteritis nodosa. There is fibrinoid degeneration followed by fibroblastic activity and sclerosis in the intima, cellular proliferation in the adventitia. If the reaction is essentially fibrinoid necrosis involving the connective tissues of skin, serous membranes, small arteries, and basement membranes of the kidney, with minimal inflammation, we speak of disseminated lupus erythematosus. In rheumatic fever the injury involves the synovial membranes of joints, subcutaneous tissues, and the connective tissue of

the heart. Here fibrinoid necrosis is overshadowed by proliferative and inflammatory changes, with the exception of the subcutaneous nodules. When the injury is less acute, more prolonged, and proliferative changes predominate, we recognize rheumatoid arthritis. The muscle fibres suffer most in dermatomyositis. If the degenerative changes are minimal and fibroblastic proliferation with sclerosis is marked, we speak of scleroderma.

These similarities and features in common may appear to link together these varied conditions into a single entity or disease unit, just as the protean reactions to the *treponema pallidum* are gathered together under the cognomen of syphilis. It seems preferable, however, to take the view that the connective tissue, when subjected to certain injuries, responds in a rather stereotyped fashion with a mixture of degenerative, exudative and proliferative changes, and that the recognition, both clinical and pathological, of the various disease entities, depends on the combination of anatomical localization and the varying response of the connective tissues.

It seems probable that hyaluronidase plays some part in the production of the lesions of the collagen diseases. This is particularly true of rheumatic fever, and in this instance salicylates seem to act as a specific inhibitor. In rheumatoid arthritis the synovial fluid is reduced in viscosity and fails to form a mucin clot, both of which attributes suggest an excess action of hyaluronidase.

### The Influence of Hormones on the Ground Substance

Reference has already been made to the fact that the ground substance is under endocrine influence. The chief of the endocrines in this respect are the sex glands, the adrenals and the pituitary, to which may be added the thyroid. (Sylvia Bensley has shown that removal of the gonads or the adrenals leads to over-maturation of collagen, whereas administration of extracts of these glands results in a cellular young connective tissue. Both ovarian and pituitary extract influence the mucopolysaccharide content of the skin and the endometrium as shown by the degree of metachromasia.)

The permeability of the ground substance may be increased or decreased experimentally by the use of hormones. Estrogenic hormones decrease permeability by causing the formation of large amounts of hyaluronic acid and chondroitin sulphuric acid. Gonadotropic hormones increase the permeability, and the mucopolysaccharides are found to be more water-soluble. Adrenal cortical extract and ACTH decrease the permeability;

adrenalectomy increases it. Thus there are two groups of hormones which have opposite effects on the ground substance.

It is, of course, the dramatic effect of adrenal cortical hormone and the ACTH which activates it on the clinical manifestations of the collagen diseases that has raised our interest in this subject to the boiling point. These effects have never been surpassed for sheer drama in the whole history of therapy. I shall not weary you with recounting them once again. But what do these effects mean? We know how difficult it is to say with certainty what is the essence of disease. The clinical manifestations seem to depend on the reaction of the tissues to the injury inflicted on them rather than on the etiological agent, although it is the name of this agent which gives its name to the disease. The hormones under consideration seem to block this reaction, to induce a more normal state in the intercellular substances, and to prevent the proliferation of mesenchymal cells. This action can be seen in experimental periarteritis nodosa and Blanchard and Hunt have watched the lesions in excised cutaneous nodules of rheumatoid arthritis waxing and waning, depending on whether cortisone and ACTH were withheld or continued.

### Conclusion

I have already taxed your patience to the limit, and I fear that I have provided no answer to the many questions which are calling so loudly for an answer. I hope I have shown, however, that fibrinoid necrosis is the function of a number of variables, and that the ground substance of the mesenchyme is a battle ground in which the forces of good and the forces of evil meet in deadly combat, that the outcome of the conflict is unpredictable, but that in the future we may be able to supply a task force which will render victory assured.

In the opening of this discussion I suggested that the frail house in which we live depends for its welfare upon its cement and ground substance as well as on the bricks and stones, the cells and fibres, of which it is composed. May I recall to you in conclusion the parable of the wise man who built his house upon a rock; and the rain descended, and the floods came, and the winds blew and beat upon that house, and it fell not, for it was founded upon a rock. But the foolish man built his house upon the sand; and the rain descended, and the floods came, and the winds blew and beat upon that house, and it fell, and great was the fall thereof. Let us pray that we may have good ground substance in our mesenchyme.



# The Indispensability of Stress

HARRY L. ARNOLD, JR., M.D.

HONOLULU

SAMUEL LANGHORNE CLEMENS (Mark Twain) once observed that the Devil had never been given a square deal: everyone criticized him, but no one ever defended him, much less praised him. "This," said Mr. Clemens, "is un-American. It is un-English. It is French."

It is much the same way with the phenomenon of stress. Since Selye first began writing about the General Adaptation Syndrome some fifteen years ago, the concept of "alarming stimuli," or more recently "stressor" or "stress" agents, has been occupying an increasingly prominent place in medical literature, and almost always in the role of a villain. Like the Devil, it seems to need someone to present its defense, even though the verdict seems already to have been rendered.



DR. ARNOLD

## Stress and the General Adaptation Syndrome

What is stress? What are "stressor agents"? Selye catalogues them as follows: trauma, bleeding, burns, heat, cold, x-rays and other ionizing radiations, sunlight, electricity, nervous stimuli, exercise, rest (!), anoxia and asphyxia, infections, anaphylactic reactions, drugs and other poisons, hormones, and diet. The common denominator of all these is that they are potentially harmful, even lethal, to their victim; and if he is to survive a severe exposure to any of them, he must react defensively against them.

The mechanism of this reaction has been described and defined by Selye under the names of the alarm reaction and the general adaptation syndrome. These consist in barest essence of increased pituitary secretion of corticotropin (the adrenocorticotrophic hormone, or ACTH), which causes the adrenal cortices to secrete increased amounts of the several adrenal cortical steroid hormones; these in turn act on the peripheral tissues to help them defend the whole organism against the enemy. It is when this defensive re-

sponse is inadequate, excessive, or abnormal, that the "stress diseases"—the rheumatoid group, the "collagen" group, the allergic-psychogenic disturbances, hypertension, peptic ulcers, and so forth—are produced. The concept is still incompletely developed, obscure in many areas, and beset with contradictions; yet it has already proved to be an extremely useful one in both theory and practice, as we all know.

## Mild Stress and the Defensive Response

But all through this line of thought we are considering stress as purely harmful; we are speaking of severe stress, excessive stress, stress against which the body's defensive response is unsuccessful or at least incompletely successful. May not stress be harmless—even helpful? Strange as it may seem, this is true of lesser degrees of stress, degrees of stress against which the defensive reaction is successful.

This is no novel view. It is a matter of common knowledge that trauma, for example, may be invigorating when it is in the form of massage; that exercise in moderation is salutary, and rest likewise; and many drugs, fortunately for us physicians, are helpful rather than poisonous if the dose is correct. Sunlight is rated very high by the lay public as a means of improving general health, and its value in prevention of rickets is unquestioned. Even hemorrhage, in moderation, enjoyed a prolonged vogue among the medical profession a century or so ago as a therapeutic measure of wide applicability and undoubted efficacy.

Can we carry this concept of stress as a useful and necessary factor even further than this? I believe we can.

## Stress and Bacteria

Let us consider, for example—though only briefly—the effect of a lack of stress upon pathogenic bacteria. Presumably the culture medium and the incubator represent the minimum amount of stress, if the composition of the former and the temperature of the latter are optimal for the bacterium in question. It is well known that a great many pathogenic bacteria, thus deprived of stress to the greatest possible extent, become much less virulent (e.g., B.C.G.); and presumably this represents deterioration, when viewed from the standpoint of the organisms concerned.

The converse situation, of repeated passage through animals unable to defend themselves suc-

Presidential Address, read before the Sixty-second Annual meeting of the Hawaii Territorial Medical Association, May 3, 1952.

cessfully against the infections thus produced, is well known to result, in the case of a great many micro-organisms, in a decided increase in virulence and pathogenicity. We have here a situation of great (though not maximum) stress (represented by the defensive reactions of the host animal) resulting in an invigorating, healthful response on the part of the organisms subjected to it, namely, the pathogenic bacteria.

If the stress is excessive, of course—e.g., the treatment accorded virulent *Salmonella typhosa* organisms unfortunate enough to be swallowed by a properly immunized adult resident of Honolulu—this invigorating effect is not observed, and the usual effect of overwhelming stress—death of the bacilli—is the result. Thus moderate stress is good for the bacteria, in a general way, and either excessive or minimal stress is bad for them—from their own point of view, at least. Soft living makes weak germs.

### Stress and Higher Plants

Higher plants manifest the same sort of phenomenon. Dehydration is surely a common source of stress so far as plants are concerned; it may be fatal to them. But moderate degrees of dehydration may be extremely salutary. Consider, for example, the wood of the silk oak, *Grevillea robusta*, as it grows in a state of moderate hydration in its native habitat, Australia. Both the common and the scientific names indicate that it is stout stuff, and so it is; it is extremely useful, in Australia, in the manufacture of furniture and barrel staves. Yet the very same tree, in the tropically rainy Guatemalan highlands, where it is widely planted for the purpose of shading coffee plantations, has utterly useless wood; soft and pulpy, it is left in the fields to rot when the tree finally falls.

Consider, further, the flowering of plants in general, and of orchids in particular. It may be over-rationalization to regard this phenomenon as a particularly healthful one, and yet it is one of the normal functions of any plant to reproduce its kind. It is a matter of common knowledge that plenty of water—not an excess, just a great sufficiency—will severely repress the blossoming of most orchids, whereas comparative drought—other things being equal—is accompanied by normal blooming. Again, just a little stress—not too much but just enough—is good for the plant.

Another example of a stress effect is the Chinese custom, familiar to most residents of Hawaii, of beating a litchi tree in order to make it bear. Presumably pounding a tree trunk with a club constitutes stress: it seems likely that it might be possible to kill a tree in this way. Yet just *enough*

pounding is widely believed to induce flowering and the growth of fruit. An alternative treatment, tightly wrapping the limbs with wire, provides another example of a helpful and stimulating effect of—not too much, but just enough—stress.

### Stress and Animal Tissues

#### *Skin*

Let us leave plants and turn to animal tissues, first of all the skin, which is the recipient of a good deal of stress in a good many different forms. A familiar variety is friction, well known as potentially harmful to any boy who has slid down a rope or wrestled on a canvas covered floor. But what does friction *in moderation* do to the skin? It thickens it, causes it to become calloused, and enables it to withstand more friction than it could tolerate before. Another is sunlight, and many a sun-bather can testify to the fact that this a potent stressor agent, capable of producing severe second degree burns; it is also able, as most doctors are aware, to cause severe skin lesions in abnormally sensitive persons, and even fatal systemic illness in persons with lupus erythematosus. In large amounts and over long periods of time, it induces in the collagenous and elastic connective tissue fibers in the skin that degenerative change which we associate with senility. Yet in moderation it has an effect on the skin which is generally regarded as a salutary one—moderate thickening of the horny layer and the cosmetically desirable increase in melanin deposition commonly known as a "tan." Both of these phenomena, especially the former, are accompanied by greatly increased tolerance for ultra-violet radiation, and the former results, as well, in improved tolerance for physical and chemical injuries. Again, a little stress, enough to elicit but not to overwhelm the normal defensive response, has a good effect, not a bad one.

#### *Muscle*

The necessity of stress for muscle tissue is obvious to all. Disuse leads promptly to atrophy, and increased use to increased functional capacity. But there are other less trite examples of the harm done by absence of stress in animal tissues.

#### *Red Cells*

The red blood cells provide us with another convenient example of the good effect of a little stress. Their average concentration in the blood is notably increased in persons living at high altitudes and subjected to the stress of lower than average partial pressures of atmospheric oxygen; it is decreased in those living near sea level and



thus exposed to higher pressures. Again, a response to stress is an increase in the functional capacity of the tissue most directly affected. Relief of this stress factor, or minimization of it, results in a weakening of this capacity, i.e., a lowering of the blood count—so that we in Hawaii, who spend much of our time only a few yards above sea level, must set up our own lower-than-average standards for "normal" red blood cell counts. A little stress is good, and its absence is (relatively) bad.

#### Bone

Consider bone—first normal, then broken. Normal bone deprived of the stress of weight-bearing or muscular pull actually loses its mineral content, a process observable as the osteoporosis of disuse. Broken bones perfectly immobilized and not subjected to any weight-bearing or other stress are known to heal, in general, less rapidly and effectively than if they are kept under moderate stress, as by the Boehler walking cast or the hanging cast so useful in certain humeral fractures. As usual, sufficient stress to demand a moderate functional response is good for the tissue concerned.

#### Meteorologic Stress

The effects of the weather on the human organism have been detailed in a series of publications by the late William F. Peterson of the University of Illinois Medical School. Although he was chiefly interested in the relationship of the *patient* (i.e., the sick person) and the weather, he brought out an enormous amount of fascinating information on the relationship of the well person and the weather. All of it bears out the basic concept that moderately variable weather has a stimulating, invigorating effect on people, making them physically and intellectually superior, on the average, to those living in more equable climes. The general productivity of residents of the storm track region of the North American continent, as compared with residents of the southern states, is a case in point. It is no coincidence that the great majority of centers of manufacture and of learning are located in areas where the weather is just plain lousy.

#### Stress and Civilizations

Examples of the beneficial effect of moderate stress on animal tissues could be multiplied almost indefinitely; but let us pass on to another field altogether: the tissues of the body politic in its broadest sense—in other words, groups of human beings: communities, nations and civilizations.

The relationship of stress—minimal, moderate, maximal and excessive—to nations and civiliza-

tions has been thoroughly if not exhaustively explored in a massive six-volume treatise by Arnold Toynbee, under the title *A Study of History*. A one-volume authorized abridgment of this work by D. C. Somervell makes fascinating reading for the amateur student of history. Mr. Toynbee's basic concepts of the stress relationship may be succinctly stated by quoting from the Table of Contents, as follows:

#### VIII. *The Challenge of the Environment*

- (1) *The Stimulus of Hard Countries*
- (2) *The Stimulus of New Ground*
- (3) *The Stimulus of Blows*
- (4) *The Stimulus of Pressures*
- (5) *The Stimulus of Penalizations*

Having first established that "ease is inimical to civilization,"—or that "soft countries make soft men"—he proceeds in Chapter VII to develop the thesis that the stimulus toward civilization is roughly proportionate to the degree of the stress stimulus—provided the latter is not excessive or insurmountable. Greek civilization, for example, he points out, began and flowered in rocky, uninviting Attica rather than lush, fertile Boeotia; Chinese civilization began along the intermittently ice-choked and frequently flooding Hwang Ho River rather than along the tamer and more easily navigable Yangtse; control over North America was won by the inhabitants of the rocky, temperate New England area rather than by the earlier settlers in balmy Florida or those in subtropical Louisiana.

#### Excessive Stress

These environmental challenges are developed, one after another, by example after example, through nearly sixty pages of the Somervell abridgment and almost a whole volume of the original work, hammering home the fundamental point that hardship induces strength, and ease weakness, in countries and civilizations. In Toynbee's next chapter the parallel with our previous biologic observations is carried further, under the expressive title *The Golden Mean*. Here Toynbee demonstrates for large groups of men what we know is true of the tissues of a single man (or of a bacterium or higher plant): that excessive stress is harmful, whereas milder degrees of stress are stimulating. Thus, to cite a few of his examples, the Scandinavian civilization reached a higher level in rough, remote Iceland than it had done in Norway; but a further progression to excessively rugged Greenland proved to be a losing battle. Along our own Atlantic coast, New England's preeminence in our national history—as compared to the smaller part played by South Carolina,

Georgia and Florida—is centered largely in Massachusetts, Rhode Island and Connecticut, rather than further north in the relatively bleak and cold area of Maine and New Hampshire. Among a series of different examples he cites the comparative success, especially in a business way, of Chinese emigrants to Malaya or Indonesia, where the stimulus of emigration has had in general a highly beneficial effect on them; and the comparatively poor performance of similar emigrants in the less hospitable environments they have encountered in Australia and California. This last observation is confirmed, interestingly, by the observation that, whereas Chinese in China have no higher incidence of circumscribed neurodermatitis than other races do (about 3 to 4 per cent of all dermatoses), Chinese in Hawaii have three times their share of this stress disorder, and, according to Rein, it is disproportionately common among them in New York.

Perhaps this thumbnail sketch of Toynbee's work will suffice to indicate how similarly civilizations, and plant and animal tissues, react to conditions of just enough—or too much—stress. Whether it suffices or not, space will not permit further discussion of this fascinating field; the reader is referred to the Somervell abridgment for further enlightenment.

### Emotional Stress

Emotional stress alone would require a whole series of books for its elucidation. How many public-spirited citizens are public-spirited citizens largely because they were stimulated by the stress factor of inadequate affection and admiration in childhood, and developed in adult life an almost insatiable appetite for public acclaim as a result of it? How many nurses and physicians derive pleasure from the sympathetic care of the sick and injured, largely because they are still driven by emotional stresses built up during a moderately unhappy childhood? How many indomitable civil engineers forsake the ease of home and fireside for the rigors of bridge-building on the frontiers of civilization, chiefly because of ungratified childhood desires which left them with drives and urges to which they respond unconsciously in this constructive and productive way?

What would be the result of an ideally secure and happy childhood, with never an emotional strain, never a verbal denial or an unmet emotional need, never a moment's sense of insecurity or of the lack of anything important? One can imagine that the resulting adult would be a dull and spiritless fellow indeed, with few or none of the inner drives that characterize our most interesting and useful friends.

### The Value of Stress

Where does all this lead us? Well, since human beings are the sum of their own tissue responses, and civilizations are the sum of the responses of their individual members, it seems an inescapable conclusion that human beings, like all living matter, are benefited by moderate stress and harmed by an excess of it or by a lack of it. It follows, then, that we must see stress in its true light, and not seek blindly to eliminate it, but make every effort to simply moderate it wherever it appears to be excessive. Indeed, we should undoubtedly strive to increase it where it seems deficient!

The applicability of this line of reasoning to the operation of the public welfare business is self-evident. Its applicability to the basic tenets of communism (Marxist, not Stalinist) and even socialism, while less obvious, is worthy of serious consideration. Natural laws are ineluctable. As Horace said, *Naturam expellas furca, tamen usque recurret*—you may throw Nature out with a pitchfork, but she will keep coming back. And if the indispensability of stress is a basic biologic law, as it appears to be, it must be taken into account, for it will keep coming back.

### Conclusion

In conclusion I should like to quote a prose poem by Hans Selye which appears on the dedication page of his *Stress*,<sup>1</sup> for it sums up the general concept of the relationship between human beings and the stresses that afflict them—or bless them—in a most beautiful way. "This book is dedicated," says Dr. Selye, "to those who suffer from stress":

*"To those who—in their efforts for  
good or evil, for peace or war—  
have sustained wounds, loss of blood,  
or exposure to extremes of temperature;  
hunger, fatigue, want of air,  
infections, poisons, or deadly rays.*

*To those who are under the  
exhausting nervous strain of pursuing  
their ideal—whatever it may be.*

*To the martyrs who sacrifice themselves  
for others, as well as to those  
bounded by selfish ambitions,  
fear, jealousy,*

*—and worst of all by hate.*

*For my stress stems from the urge to help  
and not to judge.*

*But most personally,  
this book is dedicated to my wife,  
who helped so much to write it,  
for she understood that I cannot, and  
should not, be cured of my stress,  
but merely taught to enjoy it."*

1020 Kapiolani St.

<sup>1</sup> Selye, H.: *Stress*. 1950, Montreal; Acta, Inc.



# Potassium Bromate Poisoning

## Incident to Ingestion of "Cold Wave" Neutralizer

LT. COLONEL WALTON M. EDWARDS, M.C., U.S.A.

COLONEL CHARLES L. LEEDHAM, M.C., U.S.A.

HONOLULU

REPORTS of potassium bromate poisoning from ingestion of "cold" permanent wave neutralizer continue to appear in the literature.

Twenty-five million permanent wave kits are used annually in American homes.<sup>1</sup> Eight cases have been reported since 1947.<sup>2</sup> Of these, two were fatal and six recovered. One report<sup>3</sup> quotes an excerpt from a letter written by a Medical Consultant for the Toni Corporation that the bromate neutralizer has been replaced by a non-toxic substance.



COLONEL EDWARDS

The following case is reported to illustrate successful management of the condition by conservative measures consisting principally of the judicious employment of fluids.

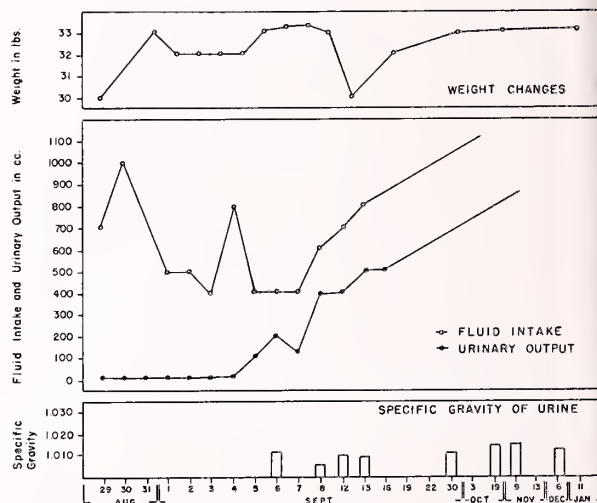
### Case Report

A two year old Caucasian boy was believed to have ingested an undetermined amount of "cold" permanent wave neutralizer powder (potassium bromate) on August 28, 1950. He was discovered playing with a previously unopened package of the dry powder, the package half full, with an undetermined amount on the floor. Although none of the substance was noted on the mucous membranes, his mouth was rinsed out with water. At a local dispensary, mustard water by mouth and a soapsuds enema were advised. The parents misunderstood the directions and inadvertently gave both mustard water (2 tablespoons) and soapsuds (3 tablespoons) by mouth two hours after ingestion of the powder. Three

hours later, he began to vomit and retch and this recurred 6 or 8 times during the night. He was unable to retain any fluids offered by mouth. The parents were unable to recall if he urinated. Four hours after ingestion of the substance, he began having liquid stools, a total of 8 to 10 times during the night. Eighteen hours after ingestion he was hospitalized at Tripler Army Hospital.

Physical examination at the time of admission disclosed a child with a temperature of 101° F., pulse of 140, and respirations of 20. Blood pressure was 90/70; weight, 30 pounds; height, 37½ inches. The patient was moderately dehydrated, drowsy and lethargic. He would vomit and lay his head in the vomitus, apparently too fatigued to move. He pleaded constantly for water. The periorbital tissues appeared sunken. The pharynx was injected. Skin tissue turgor was poor. There was a generalized hypotonicity of all muscles. The physical examination was otherwise negative.

Laboratory data are shown on the accompanying charts.



At the time of admission, potassium bromate intoxication was not considered to be the primary factor in the vomiting and diarrhea as the amount of the dry powder ingested was thought too small to be significant. It was felt that his symptoms were secondary to the emetic action of unintentional administration of mustard water and soapsuds by mouth. He was therefore given a clysis of 500 cc. of 2½% glucose in one-half normal saline in an attempt to restore his fluid balance. On the following day, forty-eight hours after ingestion, when no urine appeared, the diagnosis of intoxication due to potassium bromate ingestion was more seriously considered.

From the Pediatrics Section, Tripler Army Hospital, APO 438.

<sup>1</sup> Editorial Comment, J.A.M.A. 144:397 (Sept. 30) 1950.

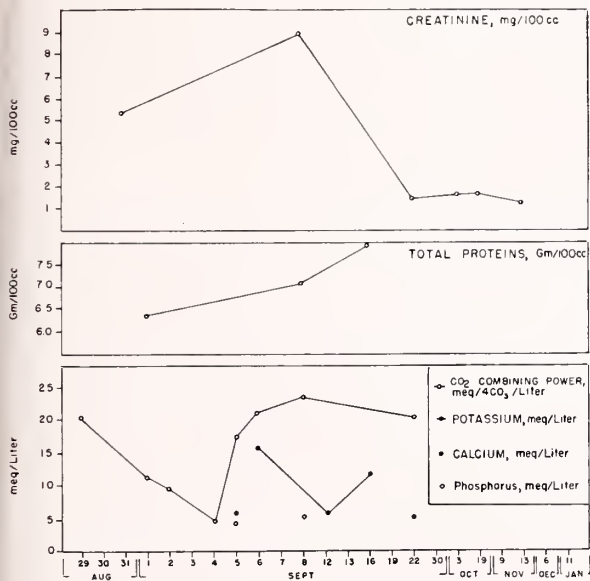
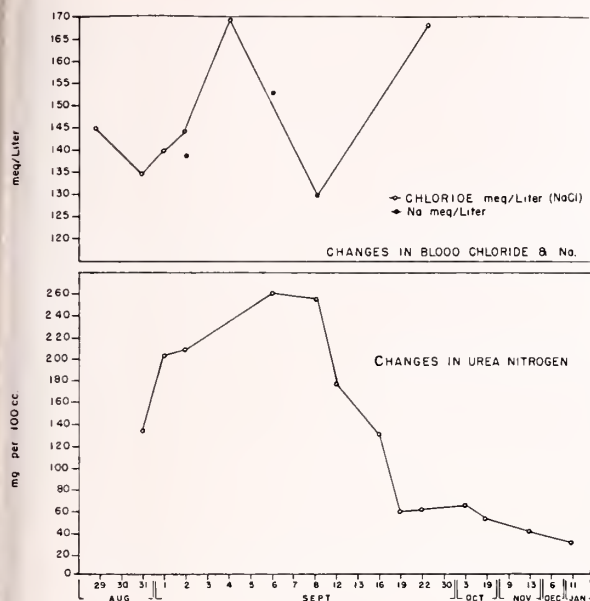
<sup>2</sup> Dunskey, I.: Potassium Bromate Poisoning, Am. J. Dis. Child. 74:730, 1947.

Thompson, H.C., and Westfall, S. W.: Potassium Bromate Poisoning; Report of a case due to ingestion of "Cold Wave" Neutralizer, J. Pediat. 34:362, 1949.

Kitto, W., and Dumars, K. W.: Potassium Bromate Poisoning, J. Pediat. 35:197 (Aug.) 1949.

Robertson, F.; Flothow, M. W., and Kissen, M. D.: Potassium Bromate Poisoning; Report of Case, J. Pediat. 36:241 (Feb.) 1950. Carratala, R., and Ureary, L.: Grave Intoxication due to Ingestion of Potassium Bromate, Rev. Assoc. Med. Argent. 55:529, 1941.

Warren and Gross.<sup>3</sup>  
<sup>3</sup> Warren, S. A., and Gross, W. V.: Report of a case of Potassium Bromate Intoxication, Pediatrics 5:954 (June) 1950.





DATE	FLUID INTAKE	URINE OUTPUT	SG. URINE	BUN MG/100 CC	CREATININE MG/100 CC	CO <sub>2</sub> MEQ/HCO <sub>3</sub> /LITER	CL MEQ/LITER.... (AS NaCl)	NA MEQ/LITER	K MEQ/LITER	TOTAL PROTEINS GM/100 CC	Ca MEQ/LITER	P MEQ/LITER	SG. BLOOD	SG. PLASMA	RBC (MILLIONS)	HB. (GM %)	HEMATOCRIT	WBC	WEIGHT/LBS.
29 Aug.	700	0				20	145								3.3	13.1	39	14800	30
30 Aug.	1000	0																	
31 Aug.	1100	0		132	5.3		135								3.3	10.1	32	15600	33
1 Sept.	500	0		200		12	140			6.3			1045	1024	3.2	10.0	31	13500	32
2 Sept.	500	0		206		9.8	144	137							2.8	9.3	30	10000	32
3 Sept.	400	0													3.0	8.4	26		32
4 Sept.	800	10		174		4.9	169												32
5 Sept.	400	100				17					5.35	4.35							33
6 Sept.	400	200	1011	247		21		153	15.5										33 1/4
7 Sept.	400	130																	33 1/4
8 Sept.	600	395	1005	242	8.8	23	128			7.0		5.0	1044	1026		8.6	25		33
12 Sept.	700	400	1010	175					5.5										30
13 Sept.	800	500	1009										1044	1028		7.9	23		
16 Sept.	Ad Lib	500+		130					11.8	7.8									32
19 Sept.	"	"		58															
22 Sept.	"	"		63	1.4	20	167				5.25				2.3	7.3	24	10000	
30 Sept.	"	"	1012												2.2	7.0	22	10000	33
3 Oct.	"	"		65	1.5														
19 Oct.	"	"	1013	55	1.5										3.2	9.2	29	10000	33
9 Nov.	"	"	1014												3.5	8.6	29	10000	
13 Nov.	"	"		42	1.2														
6 Dec.	"	"	1012												3.6	9.0		9000	
11 Jan.	"	"	1027	31											3.6	9.8	31	5000	33

were dealing with a case of anuria from other causes probably due to ingestion of potassium bromate, and a conservative regimen of treatment was instituted as has been advocated in the literature.<sup>5</sup> This regimen has the object in view of tiding the patient over during the destructive phase of the toxic process until the kidney could resume normal function. Accordingly, therefore, fluids were limited to 400-500 cc. daily, based on the replacement of the normal fluid loss through the lungs, skin, stool in children.<sup>6</sup> A normal intake of fluid daily might have been detrimental in producing acute urinary retention with pulmonary edema and respiratory failure. The daily weight remained constant and served as a check on the proper amount of fluid to administer.

As a result of the severe acidosis which developed (manifested by a carbon dioxide combining power reported as 4.9 mEq HCO<sub>3</sub> per liter) he was given M/6 sodium lactate. This was a calculated hazard as the kidney was unable to

excrete the sodium ion; however, it was felt that the risk was indicated because of the acidosis. This was administered at the time the urine appeared.

Hyperpotassemia was noted, the blood level of potassium being 15.5 mEq per liter on the ninth hospital day. The elevated potassium was believed to be due to the ingestion of the potassium bromate plus the inability of the kidney to excrete the cation and the increased amount of potassium by endogenous potassium metabolism. Electrocardiograms taken frequently remained normal in spite of the high potassium. This hyperpotassemia is at or near the fatal level and is difficult to explain, especially with a normal electrocardiogram. The determination of the serum potassium was made by gravimetric analysis, not by flame photometry, and the value may be in error. It has been observed, however, that electrocardiographic findings and serum potassium concentrations do not always correlate.<sup>7</sup>

Duodenal lavage was instituted on the third hospital day because of the increasing azotemia.<sup>8</sup>

<sup>5</sup> Odel, H. M.: Acute Renal Failure; Important Objectives in Conservative Management, *Med. Clin. North America* 33:1007 (July) 1949.

Muirhead, E. E.; Vanatta, J., and Grollman, A.: Acute Renal Insufficiency, *Arch. Int. Med.* 83:528 (May) 1949.

Pratt, E. L.: Treatment of Anuria, *Am. J. Dis. Child.* 76:14 (July) 1948.

<sup>6</sup> Levine, S. Z.; Wheatley, M. A.; McEachern, T. H.; Gordon, H. H., and Marples, E.: Daily Water Exchanges in Normal Infants, *Am. J. Dis. Child.* 56:83 (July) 1938.

<sup>7</sup> Tarail, R.: Relation of Abnormalities in Concentration of Serum Potassium in Electrocardiographic Disturbances, *Am. J. Med.* 5:828 (Dec.) 1948.

<sup>8</sup> Marquis, H. H., and Schnell, F. P.: Treatment of Anuria With Intestinal Perfusion, *Am. J. Med. Sci.* 215:686 (June) 1948.

Hicks, M. H.; Crutchfield, A. J., and Wood, E. J.: Intestinal Lavage in the Potassium Intoxication of Lower Nephron Nephrosis, *Am. J. Med.* 9:57 (July) 1950.

This procedure was decided upon because of its simplicity of application in preference to peritoneal lavage.<sup>9</sup> It was of doubtful value during the seven days of its application as there were no significant drops in the blood urea nitrogen, the level ranging from 175 to 245 mgm/100 cc. The concentration of the urea nitrogen and potassium in the returns from the duodenal lavage was not determined.

After five months of follow-up, the patient continued to have signs of renal insufficiency manifested by an elevated fasting blood urea nitrogen

of 31 mgm/100 cc. The ability of the kidney to concentrate has returned to normal as evidenced by a specific gravity of 1.027. Clinically he has progressed satisfactorily. He has been alert, active, and well nourished, and his anemia has responded to the ferrous sulfate medication.

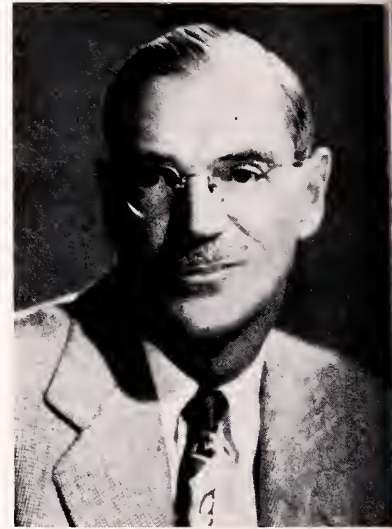
### Conclusion

This case is believed to be compatible with potassium bromate poisoning from ingestion of permanent wave neutralizer, because of similar reports cited in the literature, the physical findings, laboratory determinations of a high blood potassium, and the clinical course of the patient.

<sup>9</sup> Odel, H. M.; Ferris, O.D., and Power, M. H.: Peritoneal Lavage as an Effective Means of Extrarenal Excretion, *Am. J. Med.* 9:63 (July) 1950.



## *The President's Page*



### THE MINORITY GROUP

Were all people to think alike there would be no change, and with no change no progress. Where freedom of individual thought has been actively expressed and encouraged civilization has made its greatest advances. Our own nation has become great due in large part to freedom of action and thought. Our two-party system has been wholesome because the party out of power, the so-called minority group, has always acted as a check on the party in power. Dissension of opinion has tended to bring to light weaknesses as they arise. When emergencies have arisen, we have always united as one to face a common danger.

It would seem logical to encourage active differences of thought as to our own medical organization whether it be on a County, a Territorial or a National level. Expressions of disapproval of policies and programs of the medical profession is stimulating. Wrongs should be brought to light that they may be righted. Minority groups may well persist in advocating reforms or change. And like our nation let us put up a unified front against influences detrimental to our welfare as a medical organization.

If any minority group dislikes the Medical Association's tactics of lobbying, of the methods of preventing state medicine or even prefers socialization itself, let them persist in actively presenting their opinions to their colleagues. These minority groups are stimulating and strengthening. But when our organization acts in matters relating to the public, may we act as a medical unit in accordance with the will of the majority. There is little strength in secession. Very few problems are solved by running away.

A handwritten signature in dark ink, appearing to read "J. M. Carter". The signature is stylized with large, flowing loops and a prominent initial "J".

# Hawaii

## MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE HAWAII  
TERRITORIAL MEDICAL ASSOCIATION

HARRY L. ARNOLD, JR., M.D.	Editor
MRS. EDITH C. BENNETT	Managing Editor
WILLIAM JOHN HOLMES, M.D.	News Editor
R. J. McARTHUR, M.D.	Advisory Board
HASTINGS H. WALKER, M.D.	Advisory Board
HOMER IZUMI, M.D.	Advisory Board
R. YAMANOHA, M.D.	Associate Editor, Hawaii
EDMUND TOMPKINS, M.D.	Associate Editor, Maui
PETER KIM, M.D.	Associate Editor, Kauai

### [ EDITORIALS ]

#### THE A.M.A. HOUSE OF DELEGATES

The 188 elected members of the House of Delegates of the A.M.A. have been accused of being, by and large, elderly specialists elected and re-elected in perpetuity. Dr. Frank Borzell, the Speaker, has just issued an analysis of this charge.

Re-election in perpetuity seems to be a myth. The mean length of service of the 188 current members is five and one-half years; the median is only four years, since 93 members have served four years or less. Only 23 have served for more than ten years, and of these only 1 has served over twenty years.

Are the delegates elderly? Their average age, both mean and median, is 59—half of them are between 40 and 60 years old, and half between 60 and 80. There are as many over 70, as under 50. Perhaps it is unkind to characterize a man of 60 as "elderly"—but as a refutation of the charge of undue elderliness in a parliamentary body, the above figures leave a good deal to be desired.

Are they specialists? Over 90 per cent of them say they are, according to the A.M.A. Directory. Only 9.5 per cent are general practitioners, a startlingly—and distressingly—small proportion. How can the medical profession at large be properly represented by a body so overwhelmingly specialist in its composition? Of even greater concern is the implication, in these figures, that representation is overwhelmingly urban. The reasons for this seem fairly obvious; surely the reasons for taking steps to correct it are equally apparent.

Startling is the fact that 38 per cent "hold professorships"! "This indicates," says Dr. Borzell, "that education is well represented." It seems to us to indicate—indeed, to prove—that educa-

tion is far *too* well represented. No amount of intelligence, professional ability, personal charm or forensic expertness can possibly compensate for the inability of these men, as a whole, to properly appreciate the problems and viewpoints of the general run of medical practitioners. Two teachers, out of every five delegates, is at least one too many.

No criticism of the delegates, collectively or individually, is implied in all this. Nor do we mean to impugn specialists, or men over 60. Hawaii's Delegate is a specialist—a young specialist—and we think he's doing a top-notch job. And many a delegate of 70 is a more thoughtful and liberal representative of his fellows than many another of 40. Neither youth, nor residence in a small town, is a passport to competence in a delegate. Moreover, we happen to think that the A.M.A.'s House of Delegates has been doing a pretty fair job, over the years—especially recently.

But, gentle readers, not all of you think so. This is addressed chiefly to those of you that don't, —and in the U.S.A. at large, not just in Hawaii. It is also addressed to general practitioners, who may not feel that their 1:10 ratio of representation is quite adequate, and may wish to do something about it. Finally, it is addressed to the County Medical Societies of the U.S.A., whose responsibility this situation is, and whose duty it is to correct it if they think it needs correcting.

#### ST. FRANCIS HOSPITAL'S QUARTER-CENTURY

May 9, 1952, marked the twenty-fifth birthday of St. Francis Hospital in Honolulu. It was in 1927 that the Sisters of St. Francis opened their 50-bed hospital on Liliha Street, under the direction of Mother M. Flaviana (now deceased), with



Sister M. Agapita (now in New Jersey) as Superintendent. The School of Nursing was established and accredited in 1929.

In 1939 Sister M. Jolenta, the hospital's fifth Administrator, took the helm; she has managed the institution ever since, and has seen it grow to over five times its original capacity, to its present size of 213 beds and 42 bassinets.

Operated by the Sisters with the guidance of an appointive lay Advisory Board and an elective medical Advisory Committee of 8 physicians, St. Francis serves almost half again as many non-Catholics as it does Catholic patients, and has done so from the beginning. In the past year there were 7,443 admissions, 1,261 births, 3,466 surgical operations, and 18,572 out-patient visits.

The JOURNAL extends anniversary congratulations to the Sisters of St. Francis and their Hospital and wishes them success and Godspeed in their next quarter-century of effort in behalf of the community they have so ably served these twenty-five years past.

#### **MUCH OBLIGED, MARJORIE SHEARON!**

Thanks largely if not entirely to the alertness of Mrs. Marjorie Shearon, Editor of *Challenge to Socialism* and Washington legislative consultant, HR-7800, the Social Security Bill, was defeated in the House of Representatives on May 19 last. Mrs. Shearon's sharp eye detected an inconspicuous "joker" in the bill which would have opened the door to socialized medicine, and within three days alerted sufficient opposition to the bill, through the assistance of the Association of American Physicians and Surgeons and the A.M.A., to defeat it. The actual vote was 149 for passage to 140 against, a two-thirds majority being required.

It is shocking to realize that this bill was introduced May 12, first printed on May 14, reported out favorably by the Committee on Ways and Means on May 16 *without public hearings*, and voted upon on May 19.

The bill was primarily concerned with old-age benefits, but contained a proviso giving Oscar Ewing extensive control over the care of the sick.

The A.M.A. has made no official acknowledgment of Mrs. Shearon's having been the one to spot this objectionable clause, but the A.A.P.S. has publicly stated that it was all her doing. We're very much obliged, Mrs. Shearon—and that goes for the Nation, not just for the medical profession!

#### **GIVE THROUGH THE A.M.A. EDUCATION FOUNDATION!**

Financial support to your medical school will serve a double purpose if you make your donation through the American Medical Association's Education Foundation. It will help the school just as much as if you make it directly—it will be transmitted to them in the same amount in which you gave it, and will be credited to you personally by the school, and to your class if you are engaged in inter-class rivalry. It will also help you, as a member of the American Medical Association, join with other members to show the nation that the nation's doctors are opposed to Federal subsidization and control of medical schools—and that you're willing to help to prevent it if possible.

The response from individual doctors to date has been disappointing. Aside from the contributions by the California and South Carolina State Medical Associations, amounting to over \$9 per member from each one, the *average* 1951 donations by individual doctors don't add up to much over \$1 apiece.

We have just made a donation to our school—the first we ever made—through the A.M.A. Education Foundation; and we promptly got a courteous letter of thanks from the Dean, even before the actual check had arrived. So we know it works.

Dr. Min Hin Li, a loyal Jefferson alumnus, has agreed to head a committee of the Hawaii Territorial Medical Association to start a campaign for raising Hawaii's standing in this fund campaign. Let's back him up by making a donation to our own schools, and sending the check to the American Medical Education Foundation, 535 North Dearborn Street, Chicago 10, Illinois.

# THIS IS WHAT'S NEW!

---

Colloids were suspected long ago (Ebstein, 1884) of being responsible for the prevention of kidney stones, but credit must go to Butt and Hauser for the first practical advance along this line. They found the incidence of urolithiasis inversely proportional to the concentration of urinary colloids. **Hyaluronidase**, a powerful colloidal dispersing agent, was effective in preventing the recurrence of **urinary calculi** in 18 of 20 "stone-formers" for a period of eleven to fifteen months. Dosage schedule not elaborated (Butt and Hauser, *N. Eng. J. Med.* 246:604 [Apr. 17] 1952; and *Science* 115:308 [Mar. 21] 1952.)

Action is thought to be the formation of a reversible gel in combination with the crystal micelles, preventing the micelles from growing into solid crystals of inorganic matter.

A new variant of an old theme: vinegar douches to encourage acidophilic vaginal flora, now **vinegar aerosol** to control **gram-negative infection in bronchiectasis**. Currence (*Am. J. Dis. Child.* 83:637 [May] 1952) relates the wondrous tale of a 6 year old girl with bronchiectasis and copious sputum abounding in *Pseudomonas aeruginosa*, who got nowhere with five months of the "mycins" and cleared remarkably after one month of an acetic acid aerosol (two tablespoons of vinegar to one liter of water in a steam tent for fifteen minutes, t.i.d.).

**Prolonged testosterone therapy** is often effective in **apocrine diseases** (such as hidrosadenitis and Fox-Fordyce disease) says Cornbleet (*Arch. Dermat. & Syphilol.* 65:549 [May] 1952). This is particularly useful in patients with hidrosadenitis in whom the multiple draining abscesses in axillae, groins and elsewhere may not be amenable to excision and plastic surgery.

A pilot study at Brooke Army Hospital indicates that **stilbestrol** is of **no value in acne**. (White and Lehman, *Arch. Dermat. & Syphilol.* 65:601 [May] 1952.)

**Cortisone, ACTH** and **vitamin E** are **valueless** in the treatment of **retrolental fibroplasia**, according to two careful studies on over 150 infants with this condition (Reese, et al., and La Motte, et al., *Arch. Ophthalmol.* 47:551 and 556 [May] 1952.)

**Pyrazinamide** ("Aldinamide"—Lederle) is a new **anti-tbc** drug which holds only so-so promise. Its effectiveness lies between streptomycin and PAS, and resistant bacilli emerge quickly. It has a quick "pick-up" action, however, reducing cough, fever and sputum, and may prove useful in some patients.

Some startling "before and after" pictures seem to bear out Wayne Rundles' contention that **triethylene melamine** is decidedly valuable in the management of Hodgkin's disease and assorted **lymphomas** (*Blood* 7:483 [May] 1952.) "TEM" compares favorably with whole body irradiation and P-32 in patients with diffusely scattered disease. Local roentgen irradiation remains the treatment of choice in localized Hodgkin's and localized lymphomas.

More than skin deep is the similarity between **aureomycin and terramycin**, according to Pepinsky and Watanabe (*Science* 115:541 [May 16] 1952). X-ray diffraction studies indicate that the two compounds are **isomorphous**, and chemically differ only in the replacement of a hydroxyl group in terramycin by a chlorine in aureomycin.

Reviving an oldie: **intra-arterial histamine** (3 mg. histamine diphosphate in 500 cc. normal saline into the femoral artery in one-half hour) produced several months' relief of claudication in 7 of 8 patients with **arteriosclerosis obliterans** (*Circulation* 5:661 [May] 1952). Van Slyke blood analyses showed decreased oxygen tension in the femoral artery and femoral vein. Benefit was thought to be due to opening up arteriovenous anastomoses in the perfused leg.

C. A. DOMZALSKI, JR., M.D.



# TERRITORIAL MEDICAL ASSOCIATION REPORTS

## REPORT OF THE HAWAII DELEGATE ON THE A.M.A. MEETING IN CHICAGO (1952)

### I. Proceedings of the House of Delegates

First action of the House was to award Dr. Paul D. White the Distinguished Service Award for 1952, by a narrow margin over Dr. Donald Balfour.

Then the speaker of the House of Delegates, Dr. F. S. Borzell, of Pennsylvania, analyzed the ages and the term of office of the delegates.\* He found that 11 per cent of the delegates were aged 40 to 49; 42 per cent were from 50 to 59; 36 per cent from 60 to 69; and 11 per cent from 70 to 79. The average length of service of a delegate has been five and one-half years. He said, "I think it is fair to deduce from these figures that there is a healthy turnover of membership and at the same time a sound experienced membership is retained. It obviously represents a group of men elected by their constituency because of their serious interest in the objectives of organized medicine."

Dr. John W. Cline's presidential address followed. This was a review of the accomplishments in American medicine and expression of thanks to the House and Board of Trustees for their help. President Cline, during his year of office, traveled by air more than any other man in the United States. He gave over 300 addresses to medical societies all over the United States and the Territory, including, as you know, a talk to the Chamber of Commerce in Honolulu during the Pan-Pacific Surgical Congress. He closed his remarks by a condemnation of the remarks of the Chairman of the President's Commission on the Health and Needs of the Nation. Immediately after his talk, Dr. Warren Furey, of Illinois, introduced a resolution the purport of which was to voice opposition to the remarks by the Chairman of this special commission, Dr. Paul Magnuson, in his attack on the American Medical Association. Dr. Russell V. Lee, of Palo Alto, California, who is both a member of the House of Delegates from the Section of Military Medicine and also a member of this commission, arose and pleaded for moderation and asked the House to await the Commission's final report. The resolution was tabled on Wednesday, but two days later a similar resolution passed without a dissenting vote. It was the general feeling of the House that the Commission was a politically appointed group which would get President Truman "off the hook" in regard to his socialized medical program. Your delegate personally feels that the Board of Trustees of the American Medical Association should be represented on this Commission so that we might influence it and know for certain what is going on.

The next official gathering was on Tuesday evening in the grand ballroom of the Palmer House, at which John Cline passed the gavel of the Presidency of the American Medical Association to Dr. Louis H. Bauer, of Hempstead, Long Island, New York. Dr. Bauer then gave a most stirring address over two national networks. He pointed out the dangerous trends toward socialism

in this country and the constant threat of bureaucracy to engage the entire energies and tax monies of the people. He strongly urged all physicians in the United States to vote in the coming Presidential election, which he stated would settle one of the gravest questions in the history of the United States; that is, whether we are going to continue to further socialize this country or whether freedom of choice in many, many things will persist.

Of the more than thirty resolutions introduced into the House of Delegates, your Delegate was particularly interested in three. The first was a resolution by Westmorland, of New York, accompanied by about six or seven others, which disapproved the setting up of the American Board of Microbiology where non-M.D.'s would be certified by the American Medical Association in a subspecialty. A committee headed by Edgar V. Allen listened for an entire day to testimony on this subject. His Committee's recommendation for further study by the Council on Medical Service was adopted by the House.

Secondly, there were several resolutions on the care of non-service-connected disabilities in Federal and Veterans' Hospitals, with particular reference to the "Pauper's Oath." I appeared before a committee under the chairmanship of Joseph H. Howard, of Connecticut, and stated my observations at Tripler Hospital, which was one of the reasons why I resigned as a consultant to that institution. The general consensus was that no progress would be made in solving this problem unless Congress changed the law regarding the signing of this "Pauper's Oath."

The third resolution which interested your delegate was one in which it was recommended that the Section delegates be paid for attending the American Medical Association and get a per diem maintenance pay as well. It was pointed out that many very capable Section delegates were unable to attend for financial reasons as they are often full-time medical school teachers who cannot afford a lengthy trip. This resolution was approved.

On the afternoon of the last day, Thursday, of the Delegates' meeting, there was a debate on Clause III of House Bill 7300 which empowered the Social Security Administrator to decide which persons in the United States were totally disabled and to waive their Social Security payments until age 65, at which time they would start to draw benefits. The implementation of the examination and who would do the examinations and who would pay for them was left to the Social Security Administrator. The House felt that this was a long step toward socialized medicine and condemned this particular clause in the bill. (The House of Representatives passed it without hearings on June 18.—Ed.)

### II. Social Gatherings

There were social gatherings in which your delegate and alternate delegate, Dr. Homer Izumi, took an active part. The first of these was the official banquet welcoming the House of Delegates given by the Illinois and Chicago Medical Societies and also sponsored by Armour

\* See Editorial page.

Laboratories. This was at the Morrison Hotel. We had brought twenty-four large orchid leis to Chicago, and these were presented to all the officers, Trustees and guests at the speakers's table, and were quite evidently greatly appreciated. The banquet and entertainment were outstanding, the latter headlined by Dorothy Shay.

Second, each day at noon, the Blue Shield organization, of which HMSA is a member, had a smörgåsbord luncheon in a Palmer House suite. Of the 78 member plans, 54 Blue Shield organizations from all over the states and territories contributed foods representative of their area—Idaho turkey, Montana beef, Oregon salmon, Maine lobster, Wisconsin cheeses, Hawaiian pineapple from HMSA, all properly acknowledged—being examples of offerings to over 300 appreciative guests each day. As a co-operative undertaking, it was not only an inexpensive but a highly successful and popular affair on the part of Blue Shield.

Third, the Harvard Medical Alumni Association heard a talk by Mr. Clarence Randall, President of Inland Steel Corporation, a most effective speaker. He stated that large companies should invest more money in medical research. He said, "We are investing almost \$100 per man per year investigating the nature of metals, but we are not spending one cent investigating the nature of man." He pointed out that many young executives suffer from heart attacks or strokes and that business should invest money in research to find out the basic cause of these illnesses. He also urged physicians to persuade industry to have annual physical examinations.

Lastly, Dr. Izumi and I were hosts at a party on the night of our departure for everyone we could find around Chicago who was from the Islands, either past or present. About thirty people came, and we believe it was enjoyed by all.

ALFRED S. HARTWELL, M.D.  
*Delegate*

## REPORT OF THE ALTERNATE DELEGATE

Loaded with three cases of fresh pineapples and a large box of vanda orchids, Dr. Hartwell and I arrived in a sweltering Chicago the day before the opening of the AMA meeting. It is noteworthy that precautions were taken to see that your delegates this year delivered the goods as they were intended. As you recall, last year Hartwell arrived with a large box tenderly nursed across the Pacific and the U.S. as orchids. To our embarrassment they turned out to be canned Kokie chips and Guava jelly. This time the Hawaii Visitors Bureau and Crossley Associates saw that there were no spurious substitutes, while Joe Veltmann of HMSA was on hand to see that the pineapples went along as part of our personal luggage.

The opening day of the House of Delegates was highlighted by the address of retiring president Dr. John W. Cline. While his remarks were essentially a summation of American medicine's achievements in the past year, he advocated further expansion and improvement in the field of voluntary health insurance and in rural practice. While compulsory health insurance now seemed unlikely, he warned of "flanking" attacks by its proponents, among them Federal subsidizing of our medical schools. In this regard he asked for more financial aid from the profession to avoid possible Federal intervention and domination of our medical schools. In the

course of the meetings other evidence of "flanking" movements was brought to light, namely Congressional bills which had or were being introduced, which would grant the Federal Social Security Administration powers equivalent to government-controlled medicine in the old-age groups.

In the reference committee hearings, aside from those resolutions already reported by Dr. Hartwell, there were two matters discussed of possible future import to all of us. One was the growing concern over the shortage of interns and residents in many good teaching hospitals. Substitution of foreign medical school graduates, most of them having marked language handicaps and lacking the educational background of the American-schooled student, had created hazardous and frustrating situations. Suggested remedies included those of advocating two-year rotating internships beginning if necessary with the four year medical student, adjustments in creditation for American specialty board requirements, and a re-survey of all hospitals now accredited for intern-resident training with a possible view toward dropping those where facilities were considered inadequate. The matter I believe was referred to the Council on Medical Education. I was impressed not only with the widespread gravity of the problem, its possible effect on some of our hospitals, but the related remarks fostering more rotating types of training and general practice experience as a proper if not better prelude to specialization. Its import suggests the development of more men who would remain in the field of general practice.

The status of the non-MD clinical psychologist was another matter of possible future interest to us. An attempt to have the AMA set up a certifying specialty board for this group, in certain areas actively engaged in practices closely related to psychiatry, aroused considerable discussion, and was subsequently referred to the Council on Medical Services.

Due to time limitations as your delegates, neither Dr. Hartwell nor I was able to hear any of the scientific papers. However in a short afternoon's visit to the exhibits, two of general interest should be noted.

One was a display on systemic lupus erythematosus by the Cleveland Clinic, in which they pointed out that systemic lupus may exist for years in a preclinical latent form, masquerading as either epilepsy, or as syphilis through persistent false positive serologic tests. They advocated the plasma LE test on all such cases, particularly if the patient had symptoms of rheumatoid arthritis, and in treatment the use of cortisone or ACTH.

The other concerned the clinical evaluation of the Isonicotinic acid hydrazides, by the New York Seaview Hospital group. Using several of these products—Nydrazid, Rimifon, Marsilid—in tuberculosis of the lungs, the tongue, gastro-intestinal tract, bone and tuberculosis adenitis and fistulae, they revealed rapid and dramatic improvement, both in the general condition of the patient and in the tuberculous involvement. Of the drugs used, they found that Marsilid produced the most rapid and dramatic response, but also produced earlier toxic manifestations. The question of permanence of cure however was not as yet evaluated.

HOMER IZUMI, M.D.  
*Alternate Delegate*



# THE HONOLULU COUNTY MEDICAL LIBRARY

MRS. ETHEL HILL, *Librarian*  
MRS. FLORENCE GRAY, *Assistant Librarian*  
Phone 65370  
8:00 a.m.-4:30 p.m., and 7:30 p.m.-9:30 p.m.  
Monday through Friday  
Closed Saturdays at noon and Sundays  
Closed all day and evening on National holidays  
and at noon on Territorial holidays

---

## Recent Acquisitions

### Circulatory System

- Budtz-Olsen, O. E. *Clot retraction*. c1951. (gift of publisher).  
Prinzmetal, Myron. *The auricular arrhythmias*. c1952. (gift of publisher).

### Clinical Medicine

- Faddis, M. O. *Care of the medical patient*. c1952. (from Nurses' Association).  
Reifenstein, E. C., ed. *Conference on metabolic aspects of convalescence. Transactions of the 11th and the 12th meetings, 1945-46. 1946-47*. (gift of Josiah Macy, Jr. Foundation).

### Drugs

- The Merck index of chemicals and drugs*. 6th ed. c 1952. (gift of publisher).  
Penick & Co. *Bacitracin: a review . . . of the literature up to January, 1952*. c1952. (gift of Penick & Co.).

### Geriatrics

- Andrew, Warren. *Cellular changes with age*. c1952. (gift of publisher).

### Gynecology and Obstetrics

- Engle, E. T., ed. *Studies on testis and ovary eggs and sperm*. c1952. (gift of publisher).  
Parmelee, A. H. *Management of the newborn*. c1952. (gift of publisher).  
Reis, R. A. *Diabetes and pregnancy*. c1952. (gift of publisher).

### Neurology and Psychiatry

- Bender, Lauretta. *Child psychiatric techniques*. c1952. (gift of publisher).  
Brain, W. R. *Mind, perception and science*. c1951. (gift of publisher).  
Foerster, Heinz von, ed. *Cybernetics. Transactions of the 8th Conference, March 15/16, 1951*. c1952. (gift of Josiah Macy, Jr. Foundation).  
Victor, Frank. *Handwriting: a personality projection*. c1952. (gift of publisher).

### Ophthalmology

- Lancaster, W. B. *Refraction and motility*. c1952. (gift of publisher).

### Pathology

- Krajian, A. A. *Histopathological technic*. 2nd ed. c1952. (gift of publisher).

### Surgery

- Horrax, Gilbert. *Neurosurgery*. c1952. (gift of publisher).  
Moore, F. D. *The metabolic response to surgery*. c1952. (gift of publisher).  
Smithwick, R. H. *Surgical measures in hypertension*. c1951. (gift of publisher).

### Tropical Medicine

- Far Eastern Association of Tropical Medicine. *Transactions of the 7th Congress held in British India, December, 1927*. 3 v. 1927.

### Tuberculosis

- Girdlestone, G. R. *Tuberculosis of bone and joint*. 2nd ed. 1952.  
Pottenger, F. M. *The fight against tuberculosis*. c1952. (gift of publisher).  
Sellors, T. H., ed. *Modern practice in tuberculosis*. 2 v. 1952.

### Miscellaneous

- American Medical Association, Bureau of Medical Economic Research. *Subject index to bulletins and miscellaneous publications of the Bureau*. c1951. (gift of A.M.A.).  
Hall, V. E., ed. *Annual review of physiology*. v.14. 1952.  
*Quarterly cumulative index medicus*. v.48. July-Dec., 1950. c1952.  
Veterans' Administration. *Technical bulletins. Series 10*. v.5. 1951. (gift of Veterans' Administration).

\* \* \*

The May meeting of the Library Board of Governors was held during the luncheon hour, at the Pacific Club. The following officers were elected: Dr. Richardson, President, Dr. Nance, first Vice-President, Dr. Lester Yee, second Vice-President, Dr. Ishii, Secretary, and Dr. Wayne Wong, Treasurer. The Board is composed of thirteen members, and includes the following doctors in addition to the officers: Drs. Walsh, Berk, James Wong, Arnold Jr., Beck, Kawasaki, Civin and Peyton. Dr. Peyton, as Chairman of the Library Committee, attends all Board meetings in order to maintain a close liaison between the Board and the Committee.

The following doctors have been chosen to serve on the Library Committee during 1952: Drs. Peyton (Chairman), Felix, Waite, Katsuki, O. D. Pinkerton, Yamauchi, Joseph Lam, Wyatt and Lowrey. Miss Virginia Jones attends all meetings of the Committee as representative of the Nurses' Association. The Committee has been entrusted by the Board with the practical management of Library affairs, while the Board concerns itself mainly with problems of Library support.

If any member of the Medical Society has suggestions for improvement of library service or change in policy, his comments will be welcomed by officers of the Board or the Chairman of the Committee.

# BOOK REVIEWS

---

## **The External Secretion of the Pancreas.**

By J. Earl Thomas, M.D., 160 pp. with 22 illustrations, Price \$3.50, Charles C. Thomas, 1950.

In recent years, a working knowledge of the physiological activities of the pancreas has assumed greater importance, not only to the internist but particularly to abdominal surgeons who are called upon to cope with surgical lesions of this organ. The necessity or even advisability of preserving the external secretion of the pancreas following radical duodenopancreatectomy has been debated at length; and only recently, following extensive clinical observation, has it generally been recognized that it is desirable, when possible, to return the external secretion of this organ to the intestinal lumen. The role of the alkaline pancreatic juice in preventing stomal ulcers has been recognized, and how best to utilize this action in re-establishing gastrointestinal continuity has been pointed out.

Occasionally one is confronted with an external pancreatic fistula, resulting from some disease process involving the pancreas, or secondary to trauma. Under such circumstances, a knowledge of the normal physiological functions of the pancreas and the physiological imbalances that result from such a fistula is imperative for the successful conduct of such a case. Dr. Thomas in his monograph on the external secretion of the pancreas has accumulated the experimental and clinical data of other observers on this subject, in addition to his own contributions.

It would be worthwhile for anyone contemplating the handling of any surgical problem involving the pancreas to read through this short treatise on the physiology of the external secretion of this organ. You may be overwhelmed, physiologically, but you will gain some knowledge that can be applied clinically. So far as I am concerned, this monograph would have served a more useful purpose had there been a chapter summarizing the clinical application of the experimental data that has been accumulated.

J. E. STRODE, M.D.

## **The Fight against Tuberculosis.**

By Francis Marion Pottenger, M.D., 276 pp., Price \$4.00, Henry Schuman, Inc., 1952.

In writing his autobiography, Dr. Pottenger records the growth of phthisiology from poorly understood attempts at palliation to a highly specialized and effective science. It is exciting to read of a pioneer who knew such medical greats as von Behring, Calmette, Osler, Gohn, and Senator. He started with pitifully little and through diligent observation and painstaking devotion made an immense contribution to the welfare of his community and to the understanding of tuberculosis. However, this book will have a limited appeal. It will be most rewarding to patients now undergoing the "cure" and to nurses specializing in tuberculosis. Physicians may enjoy having it in their library.

VERNE L. BRECHNER, M.D.

## **Penicillin Decade (1941-1951).**

By Lawrence Weld Smith, M.D. and Ann Dolan Walker, R.N., 122 pp., Arundel Press Inc., 1951.

Don't be misled by the intriguing title of this small book. It does not depict the glories of the age of penicillin but catalogues the reactions to this most useful drug. Reactions to penicillin reported in 342 papers are reviewed. The book is a useful reference work for the physician who is interested in penicillin reactions. It should be required reading for the doctor who uses the drug without discrimination.

SAMUEL D. ALLISON, M.D.

## **The Metabolic Response to Surgery.**

By Francis D. Moore, M.D. and Margaret R. Ball, A.B., 167 pp. with 56 illustrations, Price \$7.50, Charles C. Thomas, 1952.

This is a very interesting book which represents precise chemical metabolic studies of patients who have been subjected to surgery. An attempt is made to measure and chart all of the important chemical responses in a graphic form. I doubt that many physicians will find it practical enough to warrant ownership.

ROGERS LEE HILL, M.D.

## **The Skull and Brain Roentgenologically Considered.**

By C. Wadsworth Schwartz, Ph.B., M.D., F.A.C.R. and Lois Cowan Collins, B.S., M.D., 400 pp. with 365 illustrations, Price \$10.50, Charles C. Thomas, 1951.

The authors have done very well in presenting the subject in a most concise manner. The numerous illustrations and reproductions of radiographs make it more interesting but this is almost absolutely necessary in this type of book. The descriptions are kept to a minimum, which should appeal to anyone more interested in comparing radiographs than in reading wordy descriptions. This volume is a valuable source of ready reference to the specialist in this field as well as to the general practitioner who does x-ray work in his office.

HON CHONG CHANG, M.D.

## **Office Endocrinology.**

By Robert B. Greenblatt, M.D., 545 pp. with 276 illustrations, Price \$10.50, Charles C. Thomas, 1952.

This fourth edition fulfills adequately the promise stated on the dust jacket that it is "what the practicing physician needs and wants." All subject matter is treated from the clinician's point of view, not from the experimental aspect.

Written in compendium style, this book is designed for the needs of the office practitioner other than the endocrinologist. Diagnostic procedures are outlined in specific manner and treatment is based on practical considerations. The handling of dysmenorrhea is particularly complete.

I can highly recommend this book as a satisfactory guide and refresher to practical office endocrinology.

M. E. STEVENS, M.D.



### The Scalp in Health and Disease.

By Howard T. Behrman, A.B., M.D., 566 pp., Price \$12.75, C. V. Mosby Co., Publisher, 1952.

Although the logical etiologic arrangement of this excellent text, and its attention to rare dermatoses, make it rather more useful to the dermatologist than to the general practitioner, its numerous clear illustrations and attention to practical details would make it a most useful reference work for the latter as well as the former. It is certainly what we have long needed: the definitive modern English-language text on diseases of the scalp.

Beautifully printed on glossy paper, the book offers 12 pages of prescriptions for the scalp, and there are 312 illustrations, many of them with multiple pictures. The author occasionally displays the somewhat casual optimism not infrequently manifested by men in institutional practice, as when he suggests that acne miliaris necrotica may be managed adequately without great difficulty; but in general no fault can be found with his pronouncements. The bibliography, which is extensive, is divided into sections by diseases, printed at the ends of the chapters.

This is an indispensable book for anyone whose interest in the scalp extends beyond the management of his own dandruff, with Selson Suspension—which is the only thing too new to be in the book.

HARRY L. ARNOLD, JR., M.D.

### The Auricular Arrhythmias.

By Myron Prinzmetal, M.D., Eliot Corday, M.D., Isidor C. Brill, M.D., Robert W. Oblath, M.D., H. E. Kruger and Associates, 387 pp., Price \$16.50, Charles C. Thomas, 1952.

"The Auricular Arrhythmias" represents the culmination of five years' experimental and clinical investigation of the four arrhythmias of auricular origin: auricular premature systole, auricular paroxysmal tachycardia, auricular flutter, and auricular fibrillation. This excellent monograph is both a reference work for the clinical cardiologist and internist as well as a reference for the experimental physiologist in cardiology. Much of the text is devoted to graphic illustrations and electrocardiograms which make clear what would otherwise be a difficult and less easily comprehended text. Those who have seen the motion pictures upon which part of the monograph is based must appreciate the great contribution which the authors, utilizing the technique of high-speed cinematography together with the cathode ray oscillograph and multiple channel electrocardiograph, have made in elucidating the fundamental nature of the auricular arrhythmias and establishing a rational basis for their management.

OTTO A. WURL, M.D.

### Histopathological Technic.

By Aram A. Krajian, Sc.D. and R. B. H. Gradwohl, M.D., Second Edition, 362 pp., Price \$6.75, C. V. Mosby Company, 1952.

This volume deals exclusively with the preparation of tissues for histologic and pathologic studies. It will therefore be of use, practically speaking, to pathologists and medical technicians only. This book brings up to date the author's previous edition. All routine and special staining methods are fully described as well as new staining procedures.

RAID CHAPPELL, M.D.

### Treatment of the Nephrotic Syndrome.

By Lee E. Farr, M.D., 61 pp., Price \$1.75, Charles C. Thomas, 1951.

In this monograph Dr. Farr quickly goes into the various forms of therapy popularly employed in the treatment of the nephrotic syndrome, be it due to glomerulonephritis or the so-called "lipoid" etiology. A goodly portion of this monograph goes into the therapy of edema itself, and since this is the symptom which troubles the patient and family most, it is without doubt important to have different methods for the doctor to use. Some of the therapeutic ideas forwarded by Dr. Farr, although well documented, are completely at odds with what we usually consider in our armamentarium.

There is also considerable discussion of general treatment of the nephrotic syndrome, including some of the more modern agents, such as cortisone, ACTH, and nitrogen mustard. The management of the syndrome with these drugs, as well as other methods, is discussed in a simple manner with ample quotations from the literature. In almost every instance, Dr. Farr's own views on the management of the nephrotic syndrome are clarified, so that the reader may evaluate for himself the author's position.

Many points of interest are not covered. Dietary management from the standpoint of high or low protein intake has been partially neglected. Obviously, in a monograph where brevity is urgent, points which seem important to one reader may not seem so to the next. On the whole, Dr. Farr has done an excellent job in reviewing the modern therapy of the nephrotic syndrome. More importantly, he has injected his own thoughts into this discussion, making it pleasant as well as instructive reading for the general practitioner, internist, and pediatrician.

MORTON E. BERK, M.D.

### Principles of Refraction.

By Sylvester Judd Beach, M.D., 158 pp., C. V. Mosby Company, 1952.

This book on refraction has much to offer, particularly in the field of subjective refraction. This phase of refraction is discussed in great detail. It is written in a simple style that is easy to read without any of the mathematical formulae to complicate the subject. It is a very practical little volume.

WAYNE W. WONG, M.D.

### Diabetes and Pregnancy.

By Ralph A. Reis, M.D., Edwin J. DeCosta, M.D. and M. David Allweiss, M.D., 78 pp., Price \$2.50, Charles C. Thomas, 1952.

This monograph, written by the staff of the Michael Reese Hospital in Chicago, is a well organized synopsis of the treatment of diabetes and pregnancy. It covers thoroughly the diagnosis of diabetes mellitus, the effects of pregnancy on diabetes, and the effect of diabetes on pregnancy. The management of diabetes in pregnancy and labor is discussed in a very practical way as is also the care of the newborn infant. The bibliography is excellent, extensive, and up to date.

This book is brief and easily read. It is an excellent guide to the management of the diabetic pregnant patient, especially to the physician who meets this problem only occasionally.

C. C. MCCORRISTON, M.D.

# YOGURT: Its Proved, Scientific Properties

*An authorized interview with*

**HARRY SENECA, M.D., M.S. (in Medicine) F.A.C.P., NEW YORK**

**W**HAT are the proved, scientific properties of Yogurt?

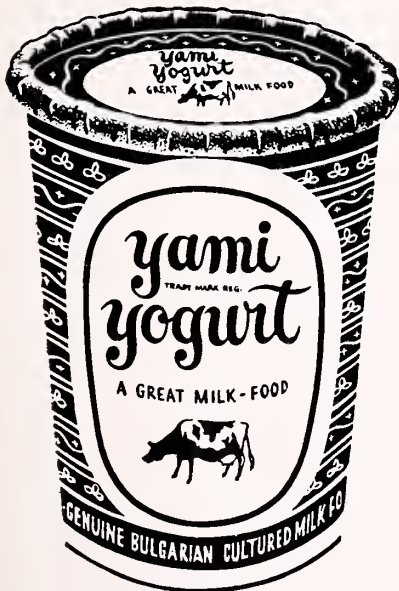
1) Easy digestibility. Yogurt is produced by a biological process in which the milk is partially digested; so that, on being exposed to the coagulating action of rennin of the stomach, it does not undergo further coagulation. Even a dysfunctioning stomach tolerates Yogurt very well. Milk, on the other hand, becomes clotted by rennin of the stomach. Such clots are digested with a certain degree of difficulty by the digestive ferments of the intestine.

2) The ability to destroy pathogenic organism. In vitro experiments show the only pathogenic organism that survives in Yogurt is the tubercle bacillus. All other organisms such as escherichia, ekectella, salmonella, shigella, brucella, bacillus pyocyaneus, bacillus proteus, pneumococcus, streptococcus, staphylococcus, endameba nistolytica, trypanosomes, leishmania, etc. are killed.

3) The ability to modify or improve pathological conditions of the lower bowel such as diarrhea and even dysentery. This action is due to the following factors: (a) the presence of lactic acid acting as an astringent on the bowel mucosa; (b) the antagonistic action between the lacto-bacilli of Yogurt and the other normal intestinal bacteria and/or pathogenic bacteria; (c) an antibiotic principle present in Yogurt.

Diarrhea that could result from the use of the broad-spectrum antibiotics, due to the overgrowth of *candida albicans*, can be corrected in most cases by the lacto-bacilli of Yogurt.

4) Constipation may be corrected in most cases if it is due to an over-balance of the intestinal bacteria in favor of the protolytic organisms. With the restoration of the aciduric organisms through either the use of Yogurt or probably high carbohydrate or vegetable diet, constipation may be corrected.



*The foregoing is presented in the interest of sound, ethical information by Dairymen's Association, Ltd., producers in Hawaii of Yami Yogurt. Your patients can secure this cultured milk-food at food stores or have it home-delivered.*

## Dairymen's

**ASSOCIATION, LTD.**

*A Division of Creameries of America, Inc.*

Be sure to listen to YOUR FRIEND, THE DOCTOR, each Sunday afternoon at 4:00 on KGMB.





# HMSA—Its Place in the Community

## Administration of the Plan

J. R. VELTMANN, *General Manager*

For the past three years, HMSA has returned over eighty cents in benefits out of every dollar invested for health protection by its members each year—a record it is proud of. During the year 1952, over one million dollars were paid to participating doctors and hospitals for services rendered its members.

The responsibility of efficient administration of this fast growing business rests with the General Manager and his staff of fifty-six employees. A Medical Director, representing the various medical societies and the Association is always available for consultation to review and interpret all technical medical questions and problems.

To assure our members, participating doctors and hospitals of prompt and efficient service, the internal functions of the Association are divided into four major classifications as follows:

1. Medical Department
2. Business Office Department
3. Sales and Service Department
4. Statistical and Records Department

The Medical Department is under the direction of the Medical Director and other departments under the supervision of qualified personnel. The larger departments are subdivided into small operating sections, and each section is headed by a trained and experienced supervisor.

In addition to these departments, there are branch offices on the islands of Hawaii, Maui and Kauai to service the people in these counties. There is also a Staff Assistant to assist all depart-

ments with their varied functions and to coordinate the activities of the branch offices.

The four Department Heads and the Staff Assistant comprise the Administrative Staff of the Association. This staff meets with the General Manager regularly once a week to review the administrative policies and discuss the problems of each department. This body has been reviewing, adjusting and reorganizing the functions of each department to effect a more stable, competent and economically operated organization, ready to serve the community, and is pleased to report that these efforts are being compensated daily as our public and professional relations improve. As a tangible result, our operating costs at the end of 1951 were 1.4% less than the previous year.

In order to maintain a constant sound administration of the plan, HMSA has initiated a training program with the ultimate aim of qualifying personnel for supervisory positions, who not only have a complete knowledge of their job, but have qualifications of leadership and the respect of each employee under their supervision. The purpose of this program has stimulated each employee to take a personal interest in his work, resulting in a more efficient and harmonious operating force. The response to this program is gratifying and its success will mean a secure and stable organization.

The employees of HMSA established the keynote of "Service" for 1952, and are ready to offer their best service to the membership, participating doctors, hospitals and the community.

(Next Issue—The Medical Department)

# COUNTY SOCIETY REPORTS

## HAWAII COUNTY MEDICAL SOCIETY

The 319th regular meeting of the Hawaii County Medical Society was called to order by President S. Kasamoto at the Lanai, Saturday, April 26, 1952, at 7:20 p.m. Members present were: Drs. Bergin, Hayashi, Kasamoto, Kutsunai, Leslie, Loo, Miyamoto, Mizuire, Okumoto, Oto, Rutherford, Tomoguchi, Ed. Wong, Yamanoha, and Yuen. Guests were Drs. Henderson of Puumaile, Faus (HMSA representative) and Bosworth (guest speaker).

As a carry over from the last meeting, two delegates and their alternates were voted on. The nominees were as follows: Delegates—Dr. N. Steuermann and Dr. T. David Woo. Alternates—Dr. T. Oto and Dr. Walter Loo. Dr. S. Mizuire moved, seconded by Dr. Pete Okumoto, that the slate be unanimously elected. Motion carried.

President Kasamoto then read the names of the men on various committees. The list will be mailed out to each member of the Society by the secretary.

Two "thank you" notes, following the birth of their baby girls, were read from Drs. and Mrs. Pete Okumoto and Nicholas Steuermann, respectively.

A letter was received from Dr. Dorian Paskowitz regarding lectures on "The Medical Aspects of Atomic Explosions," to be given in Hawaii in the near future. He also informed the Society that between May 5-10, Miss Chang and Miss Hatico will be coming to the Hilo Memorial Hospital to abstract cancer records.

Another letter, dated April 21, was received from the Hawaii Chapter of the National Foundation for Infantile Paralysis. A film titled "The Diagnosis of Poliomyelitis" is available to the Society until May 15.

The last communication, dated April 16, was received from the Health Education Committee of the Hawaii Territorial Medical Association. It is proposing a weekly radio program over station KGMB where medical subjects from the general public will be discussed by groups of doctors in a round table fashion.

The Society was informed of the application for membership of Dr. Edwin Willett of Naalehu, Kau. The application will be referred to the Board of Censors and final action will be taken later.

The Society was informed by the President that Dr. Nicholas Steuermann has been appointed to represent the Society to discuss diabetes with Dr. Morton Berk.

The proposed uniform territory-wide Industrial Accident Fee Schedule, which will be fixed by the special Fee Adjustment Committee of the Honolulu County Medical Society, was approved by the Society, after the motion of Dr. S. Mizuire, seconded by Dr. Henry Yuen. The Delegate was notified of the approval.

There being no further business, the meeting was turned over to the guest speaker of the evening, Dr. Howard Bosworth. He read a paper on "The Treatment of Minimal Lesion in Tuberculosis." This was followed by a short discussion.

The next speaker was Dr. R. Faus, Medical Director of the HMSA. He discussed the proposed agreement between the County Medical Society and the HMSA;

proposed contract between the individual physician and the HMSA; and the current status of the HMSA in Hawaii County. It was moved by Dr. T. D. Woo, seconded by Dr. S. Mizuire, and voted unanimously that the President and the Secretary be authorized to sign the proposed contract between the Hawaii County Medical Society and the HMSA. The names of the participating individual physicians who will sign a different contract with the HMSA will be sent later to Dr. Faus by the Secretary.

The 320th regular meeting of the Hawaii County Medical Society was called to order by Vice-President C. Hayashi in the absence of the President at 7:30 p.m., Friday, May 9, 1952, at Hilo Country Club. Members present were: Drs. Bergin, Brown, Crawford, Fernandez, Haraguchi, Hata, Hayashi, Kasamoto, Kaufmann, Kutsunai, Loo, Mizuire, Okumoto, Orenstein, Oto, Steuermann, Tomoguchi, Willett, Francis Wong, Woo, Yamanoha, and Yuen. Guests: Drs. Boyd, Stemmerman and Dela Cruz.

Dr. Edwin Willett was approved by the Society after recommendation from the Board of Censors.

There being no further business pending, the rest of the meeting was turned over to the honored guest, Dr. William Boyd of Vancouver, who spoke on modern concepts of cancer and bronchogenic carcinoma. Discussion followed.

RICHARD A. YAMANOHA, M.D.  
*Secretary*

## KAUAI COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kauai County Medical Society was held at the G. N. Wilcox Memorial Hospital Library on Tuesday, June 10, 1952, at 7:45 p.m. The meeting was called to order by Vice-President Dr. C. Ishii, in absence of the President. Members present were Drs. Fujii, Wallis, Masunaga, Boyden, Cockett, Kuhlmann, Ishii, and P. Kim. Dr. Harry Allison of Honolulu was guest speaker.

Minutes of the previous special meeting were read and approved.

It was announced that 100 per cent of the members had endorsed the HMSA participating physicians' agreement.

The Honolulu County's Industrial Accident Fee Schedule was reported to be on sale for \$2.00 per copy, according to the Honolulu office.

A request from the Territorial Medical Association was read regarding who now held the chairmanship of the Procurement and Assignment Committee. Dr. Ishii re-appointed Dr. Wade to be Chairman of that committee.

Dr. Harry Allison of Honolulu spoke on problems of the shoulder.

A film entitled "Coarctation of the Aorta" was shown following Dr. Allison's talk.

There being no further business, the meeting adjourned at 9:00 p.m.

PETER KIM, M.D.  
*Secretary*



## MAUI COUNTY MEDICAL SOCIETY

The Maui County Medical Society regular monthly meeting was held at the Grand Hotel on April 23, 1952. Following dinner a short business meeting was held, and then the members had the pleasure of hearing a talk by Dr. Howard Bosworth of Los Angeles on Tuberculosis. President Dr. J. A. Burden presided at the meeting.

Members present were: Drs. Cole, Underwood, Tofukuji, Fleming, Ohata, Izumi, Shimokawa, Haywood, Toney, McArthur, St. Sure, Sanders, Ferkany, Patterson, H. Kushi, Kanda, and Tompkins. Guests present were: Dr. Marie Faus, Dr. Cole, Dr. Boido, Dr. Sugino and Dr. Robert Faus. Dr. Robert Faus spoke to the Society on HMSA business.

A communication was read from Dr. Ralph Cloward, stating he would be available for a talk before the Society in July, on his spinal disc operation, should we like to have him at that time. No action was taken at this time.

A new Workmen's Compensation Fee Schedule was presented as proposed by the Honolulu County Medical Society Fee Adjustment Committee. A resolution accompanying this was indorsed by the Society, which

would attempt to put the new schedule in effect. Dr. Shimokawa moved, seconded by Dr. Ferkany, that this Society go on record as concurring with this resolution. Motion passed.

Dr. Bosworth then spoke on Tuberculosis and illustrated his talk with x-rays of patients and case histories. He stressed that changes of treatment have developed in the last few years, with necessary changes in thinking regarding the disease. He traced the history of development of chemotherapy, which, added to surgery, is the best treatment known at this time.

Using the primary and minimal lesion for an illustration, he developed the topic of immunity and allergy of tuberculosis. Along this theme, he reported a recent study conducted on 30,000 student nurses with 5 year follow-up of results. Certain definite conclusions were reached from this study, as well as new problems presented.

After a short report on the new drug, Isonicotinic Acid Hydrazid, he concluded with the warning that tuberculosis treatment is in a state of flux, and we tend to forget the basic principles of ability of the body to heal itself.

EDMUND TOMPKINS, M.D.  
*Secretary-Treasurer*

## UMI MAKAHIKI I HALA\*

We suggest you re-read: Random Notes of a Sanatorium Physician, by **D. R. Chisholm, M.D.**

### FIFTY-SECOND ANNUAL MEETING, HONOLULU, JUNE 5, 1942

A full scientific session and meetings of the membership and House of Delegates were planned as per program given. Upon advice from the naval authorities that all medical officers would be continued on the alert due to the developments around Midway Island, and upon their suggestion, it was considered advisable to postpone the scientific sessions but to proceed with the business meetings since outside island delegates were already present in Honolulu.

**Dr. R. O. Brown** was elected President for 1942-43.

### REPORT OF THE HONOLULU COUNTY MEDICAL SOCIETY (**N. M. Benyas, M.D.**)

... It was found desirable to have the doctors assemble at frequent intervals to keep informed of current plans and procedures under the defense program, and to enable them to act promptly in deciding questions of group policy. To facilitate this it was agreed to combine the regular Thursday morning clinic of The Queen's Hospital with the meetings of the society, the society taking the first half hour for announcements, discussion, and necessary action in emergency issues, and Dr. Hirsch taking over thereafter for an hour for clinic presentation. This has so far worked out very well and entirely to the satisfaction of the medical society, with an at-

tendance of rarely less than 80 persons. The well prepared clinic presentations have been a satisfactory substitute for the former scientific programs of the society.

### REPORT OF THE MAUI COUNTY MEDICAL SOCIETY (**H. H. Seiler, M.D.**)

We have lost 25% of our men to the Army and Navy which puts a lot of extra work on those remaining. Meetings were held regularly. Dr. McArthur is in charge of the medical preparedness program since Dr. Burden went into the Army. We have established three new hospitals completely from scratch at the request of the Army. The first one opened three weeks ago, and the second one opens this weekend.

### REPORT OF THE PSYCHIATRIC COMMITTEE (**R. D. Kepner, M.D.**)

This year's Psychiatric Committee has succeeded in getting established the Hawaii Territorial Society for Mental Hygiene, which was Item VI of Dr. F. G. Ebaugh's recommendations made at the time of his survey here in 1937. Members of the Medical Association occupy prominent places in this Society.

### REPORT OF THE CANCER COMMITTEE (**G. A. Batten, M.D.**)

... It is a pleasure to be able to relate that a 400 K.v. x-ray deep therapy machine has been purchased and is now on hand at Queen's Hospital. It has not been installed because no permanent facilities exist for hous-

\* Ten years ago. From Volume 1, Number 6, July, 1942.

ing it. It appears to be the present plan to defer its installation until after the war when permanent quarters will be built for the x-ray department.

#### REPORT OF THE COUNCIL

(R. O. Brown, M.D.)

... It was further recommended that the Association proceed to extend to the other counties a plan similar to the one already in operation in Honolulu, known as the Hawaii Medical Service Association plan, and that

a representative of the Council appear before the Managers' meeting of the Hawaiian Sugar Planters' Association in December.

#### HONOLULU BLOOD AND PLASMA BANK

(F. J. Pinkerton, M.D.)

A new building, 40 x 80', is being constructed on the grounds of Queen's Hospital to house all departments of the blood bank. It is expected to be ready for occupancy about the first week of July.

## CORRESPONDENCE

### NO "TREND" AT KAPIOLANI HOSPITAL?

#### TO THE EDITOR:

I am writing you in regard to the editorial titled "Kapiolani Hospital Reverses a Trend" printed in the March-April, 1952 issue of the *Hawaii Medical Journal*. It is my feeling from reading the article that there are a number of things which you do not understand about the maternal health program of the Territorial Health Department, so I will endeavor to clarify this misunderstanding, if possible.

The administrator and the staff of Kapiolani Maternity & Gynecological Hospital are to be congratulated on their willingness to take over the maternal health conference. However, I don't believe this fact is as newsworthy as you apparently thought, nor do I believe the fact that a government agency has given up an activity to a private agency is as worthy of special notice as you apparently thought. In support of this feeling on my part, I would like to point out first that this department requested the Kapiolani Hospital staff to take over the maternal health conference, and second, that the Queen's Hospital took over a maternal health conference in 1947 which had previously been operated by the Bureau of Maternal and Child Health of this Department. Other hospitals in the Territory, as well as plantation physicians and nurses, have also taken over maternal health conferences previously carried by the Health Department.

In the use of Health Department funds (in all areas) priority is given to activities where private funds are not available or where there is need to demonstrate the value of a given activity before private funds will be allocated. So I can state without reservation that the Health Department, as a government agency, is not anxious to carry any function which can be handled by a private agency. The maternal health conferences are no exception to this, so we did not feel it especially newsworthy that Kapiolani Hospital had assumed responsibility for the maternal health conference. I am sure you will agree with this point of view when you understand all the facts concerned.

C. L. WILBAR, JR., M.D.  
President, Board of Health

#### TO THE EDITOR:

The newest project in maternal health service in the territory is the Specialty Clinic held every Wednesday at the Kapiolani Out-Patient Department. Established in November 1951, this is the result of joint effort on the part of Kapiolani Hospital, staff obstetricians, and the Bureau of Maternal and Child Health of the Department of Health. This special conference brings a team of workers to study and help the maternity patients with complications. Maternity patients with special problems, i.e. medical, nutritional, social, economic, and emotional, are referred from the regular clinics of the Kapiolani Out-Patient Department. The Wednesday maternity conference is set up for the study of these cases. Health Department personnel that assist in these weekly sessions are: a nutritionist consultant, social worker, mental hygiene consultant, public health nurse, maternity nursing consultant, and the obstetrical consultant. Drs. James Mitchell and Gordon Newell, residents, and Mrs. Dorothy Ito, supervisor of the OPD, conduct the conferences.

Post clinic sessions, chairmanned by Dr. Herbert Bowles, are held at which each case is carefully considered and a plan is formulated to help the family meet their problems. Referrals are made to the various medical consultants of Kapiolani OPD, Queen's and St. Francis Hospital OPD's, Honolulu Chest Clinic, Honolulu Cancer Society, Mental Hygiene Clinic, Child and Family Service, Catholic Charities, American Red Cross, etc.

The public health nurses in the field contribute greatly as members of the team in bridging the gap between the patient and the various agencies. Follow-up reports and progress of the patients from the medical, socio-economic, and nutritional standpoint have been most encouraging. The clinic is proving to be a very educational tool and is a stimulating and interesting means of giving better total maternity care to the patients of the Kapiolani Out-Patient Department.

RUSSELL TUCKER

Administrator, Kapiolani Maternity  
and Gynecological Hospital



# NOTES AND NEWS

## PERSONALS

**Dr. A. L. Davis**, physician and surgeon at the Waialua Agricultural Company Hospital, retired after 26 years of active practice. He was honored by hundreds of children whom he had delivered and by former patients and friends at a "Dr. Davis Night" held at the Waialua Community Center.

**Dr. and Mrs. T. Alan Casey** are being congratulated on the birth of identical twin sons. The two youngsters named Patrick Charles and Michael Frank were born on May 3, 1952.

**Dr. Marcus Guensberg**, Director of the Territorial Hospital at Kaneohe, and **Dr. Agnes P. McGavin** of the Bureau of Mental Health, Territorial Department of Health, attended the annual meeting of the American Psychiatric Association in Atlantic City.

**Dr. Don Marshall** is back in Honolulu after a trip to Eastern medical centers.

**Dr. and Mrs. George D. Oakley**, both island-born graduates of Punahou School, returned to Hawaii. Dr. Oakley did his undergraduate work at the Universities of Hawaii and Southern California. During World War II, he was in the U.S. Air Corps. He received his M.D. from George Washington University. He will start his internship at the Queen's Hospital on July 1.

**Dr. Norman Sloan**, for many years Director of the Kalaupapa Hansen's Disease Settlement, is now in New Caledonia. He is making a leprosy survey for the South Pacific Commission.

**Dr. and Mrs. John M. Felix** announce the arrival of their fourth child, a son, Christopher, born on May 27, 1952.

Miss Alauana Chang, daughter of Mr. and Mrs. Harry M. Chang, was married at Central Union Church on May 17, 1952 to **Dr. Richard K. C. Lee**, assistant Health Executive of the Territorial Board of Health.

Due largely to the efforts of **Dr. Clarence Trexler**, the Pacific Coast Oto-Ophthalmological Society will hold its annual meeting in Honolulu in the spring of 1954. This will mark the first time a large mainland medical society has travelled to Hawaii for its annual convention!

**Dr. Jim Marnie** has been appointed physician for the University of Hawaii football team.

**Dr. Margaret Yamasaki**, a native born Honolulu, formerly associated with the Tokyo Army Hospital in Japan, has begun a year's internship at the St. Francis Hospital.

**Dr. and Mrs. Calvin Caramela** are returning to the mainland after a three year stay at Kahuku.

**Dr. W. Harold Civin** attended the 43d Annual meeting of the American Association of Cancer Research in New York.

**Dr. Robert C. H. Lee**, President of the Hawaii Philatelic Society and head of the Tan Shan chapter of the China Stamp Society, has been appointed Stamp Editor of the Honolulu Advertiser.

**Dr. Ruth Sison**, formerly staff psychiatrist at the Territorial Hospital, Kaneohe, has entered private practice in association with **Dr. H. Joseph Simon**. Dr. Sison is a graduate of the University of Indiana. She interned at

the Indiana University Medical Center and the University of Illinois Research Hospital. She received her psychiatric training at the Elgin State Hospital, Elgin, Illinois and at the Norway's Sanatorium in Indianapolis, Indiana. Though Dr. Sison is doing general psychiatry, she is particularly interested in child psychiatry.

**Dr. William Wynn**, kamaaina Honolulu physician, left the islands permanently. The Doctor's plans are still indefinite. However, he intends to re-enter the practice of medicine in Louisiana or Alabama.

**Dr. and Mrs. Douglas Murray** left for a three months' Mainland trip. Dr. Murray attended the American Medical Association convention in Chicago.

Also off for Chicago are **Dr. and Mrs. Louis Buzaid**, where Dr. Buzaid will attend the annual meeting of the American Radium Society.

A Subsidiary Board of the National Board of Medical Examiners, empowered to conduct the final qualifying examination of the National Board, has been established in Hawaii. **Dr. Sumner Price** is the newly appointed secretary of this Board.

**Dr. Harry L. Arnold, Jr.** was elected President of the Hawaiian Academy of Science.

**Dr. Garton Wall** of Ewa left for Mexico City to attend the Rotary International Convention. Attending the same convention is **Dr. R. C. Dusendschon** of the Medical Group.

**Dr. Richard Treadwell**, formerly physician at the Kohala Sugar Company and now practicing at San Luis Obispo, returned to the islands for a month's vacation.

**Dr. Charles Wilbar**, President of the Board of Health, was elected President of the Honolulu Lions Club for the coming year. Dr. Wilbar, accompanied by his family, left for a two months' visit to the mainland.

**Dr. Dorian Paskowitz** was elected President of the Mental Health Society for the year 1952-1953.

**Dr. Thomas Richert** returned in June from a month's tour of the Orient in the capacity of Ship's Surgeon aboard the S. S. President Cleveland. He took the job on 3 hours' notice, in an emergency created by the sudden illness of the ship's regular physician.

**Dr. Peter J. Washko** spent two weeks in Japan on a combination business and pleasure trip. While there he visited the Army Hospitals at Kyoto and Tokyo.

**Dr. and Mrs. Ralph Cloward** left for Victoria, B.C., to attend the annual meeting of the Harvey Cushing Society.

**Dr. and Mrs. John Frazer** announce the birth of their first child, a daughter, Karin Ann, born on May 7, 1952.

**Dr. Paul Withington**, kamaaina Honolulu physician and chairman of the Territorial Boxing Commission, married Mrs. Rose Lane Schroeder of Honolulu during the early part of April 1952.

**Dr. Steele F. Stewart** returned to Honolulu briefly after a tour of inspecting military medical installations in Japan and Korea. He then flew to Los Angeles to attend the wedding of his daughter, Carolyn Ruth, to Kenneth Van Winkle Dole. He then flew to England and France for two weeks.

**Dr. and Mrs. Harold M. Johnson** and **Dr. and Mrs. H. L. Arnold, Sr.** left in June, and **Dr. and Mrs. Harry L. Arnold, Jr.** in July, to attend the International Congress of Dermatology in London, England. Dr. Arnold, Jr. is to read a paper on the use of nicotine in a pilomotor test for the exclusion of the diagnosis of leprosy. All three couples plan to travel on the Continent before and after the meeting.

**Dr. James W. Cherry** returned in June with Mrs. Cherry and their children from a year's surgical residency at the Lahey Clinic in Boston, Mass. He has resumed his practice at the Straub Clinic.

**Dr. Daniel Whang**, a recent graduate of the Albany Medical College, returned with his family in June.

**Dr. and Mrs. Stewart E. Doolittle** returned in June from a two months' professional and pleasure trip to the Mainland.

## Hawaii

**Dr. and Mrs. Nicholas Steuermann** became the parents of a baby girl—**Michell Ninette**—born on March 14, 1952.

**Dr. and Mrs. Hoei Higa** welcomed their first child—**Jacqueline Meiri**—on March 14, 1952.

Death: **Dr. William E. Howes**, who recently joined the Radiological Department at Hilo Memorial Hospital, died very suddenly on April 6, 1952 of pulmonary embolism following surgery.

**Dr. T. Watanabe** of Honolulu is temporarily replacing the late Dr. William E. Howes, Head of the Department of Radiology.

**Dr. L. R. Fernandez**, Laupahoehoe, Hawaii, has accepted the position of Residency in Surgery at the Queen's Hospital beginning July 1.

**Dr. E. Willett**, Naalehu, has been accepted as a member of the Hawaii County Medical Society.

## Kauai

**Dr. and Mrs. Sam Wallis** were busy entertaining **Dr. and Mrs. Howard Bosworth** and **Dr. and Mrs. William Boyd** during the month of May. No wonder the visiting doctors like Kauai.

**Dr. Marvin Brennecke** and **Peter Kim** also took part in entertaining Dr. and Mrs. Bosworth during their stay

here. Dr. Brennecke, as usual, was a grand host and treated them to a Hawaiian luau. Dr. Kim initiated Kauai's hospitality with a luncheon at Mahelona.

Congratulations to **Clyde Ishii** for a bouncing baby boy. The happy event took place last month.

The Army is calling for energetic young physicians and **Keith Kuhlmann** of Koloa has been given an invitation by Uncle Sam. He is leaving at the end of this month for Texas. That leaves Koloa without a doctor.

The Chicago Medical Convention will have a representative from Kauai in **Marvin Brennecke**, President of the local Society.

**Kenneth Fujii** has that far away look in his eyes again and may plan another trip. Just so long as he doesn't have to lose a lot of weight like **Bill Goodhue** is still trying to do.

The Samuel Mahelona Memorial Hospital for tuberculosis opened its new 97 bed building in Kapaa, Kauai on June 14. **Dr. Peter Kim**, formerly of Honolulu, is the superintendent and medical director.

## NEWS

### Your Friend—The Doctor

Local doctors are being invited to participate in a new and unusual radio program titled "Your Friend—The Doctor" now being heard over radio station KGMB each Sunday afternoon from 4 to 4:30. This is the first time a venture of this kind has been attempted in Hawaii.

The programs feature a panel of three local doctors—different for each program—who answer questions sent in by the general public and read to them by Mr. Larry Stevens, the moderator. Each program is tape recorded well in advance of the day of presentation.

It is felt the program will create immeasurable goodwill by showing the willingness of local doctors to give of their time and knowledge freely and without compensation. It cannot help but further the cause of health-consciousness among the people of Hawaii.

The program is being underwritten by Dairymen's Association, Ltd., the organization which produced the award-winning booklet "How Hawaii's Health is Guarded" now being used as a textbook in the schools of Hawaii.



# Sixty-second Annual Meeting

## Hawaii Territorial Medical Association

**Honolulu, Hawaii**

**May 1-4, 1952**

The sixty-second annual meeting of the Hawaii Territorial Medical Association was held in Honolulu, Hawaii, with scientific meetings and exhibits being held in the Mabel Smyth Memorial Building. The following program was presented:

### SCIENTIFIC PROGRAM

- The Treatment of Alcoholism, with Special Reference to Antabuse Therapy*, by J. Robert Jacobson, M.D. Morton E. Berk, M.D., discussant.
- "Primary" Glaucoma and its Relation to General Disease*, by O. D. Pinkerton, M.D.
- Fracture of the Carpal Navicular*, by Carl M. Rylander, Colonel, M.C., A.U.S., Tripler Army Hospital (by invitation). J. Warren White, M.D., discussant.
- The Cutaneous Manifestations of Systemic Disease*, by Harold M. Johnson, M.D. Harry L. Arnold, Jr., M.D., discussant.
- The Management of the Cleft Lip and Palate Child*, by Wayne W. Wong, M.D. Dwight H. Uyeno, D.D.S., discussant.
- The Indispensability of Stress*, by Harry L. Arnold, Jr., M.D.
- The Pathology of the Ground Substance of the Mesenchyme*, by William Boyd, M.D., Professor of Pathology and Bacteriology, University of British Columbia (by invitation).
- The Place of Radical Surgery in the Treatment of Cancer of the Uterus*, by Robert G. Hunter, M.D.
- Pulmonary Embolism and Infarction*, by Henry C. Gotshalk, M.D. Rogers Lee Hill, M.D., discussant.
- An Evaluation of Present Method of Treatment of Pulmonary Tuberculosis*, by Howard W. Bosworth, M.D., Clinical Professor of Medicine, University of Southern California School of Medicine (by invitation).
- The Mismanagement of Chronic Abdomino-Pelvic Pain*, by Rodney T. West, M.D.
- Diagnostic Problems in Infectious Mononucleosis*, by J. L. Van Avery, Captain, M.C., A.U.S., and D. O. Lynn, Colonel, M.C., A.U.S. Tripler Army Hospital (by invitation). Frederick Giles, M.D., discussant.
- The Use of Dermal and Cutis Grafts in Inguinal Hernioplasty*, by Robert G. Johnston, M.D.

### MEETINGS

- Advisory Committee to the Bureau of Crippled Children*, Thursday morning, Mabel Smyth Building.
- Advisory Committee to the Bureau of Maternal and Child Health*, Thursday afternoon, Mabel Smyth Building.
- Council*, Thursday evening, Mabel Smyth Building.
- Woman's Auxiliary—House of Delegates*, Friday morning, 11:00, Halekulani Hotel.
- Luncheon*, 12:30 Friday, Halekulani Hotel, followed by Fashion Show and Annual Meeting.
- House of Delegates*, Friday afternoon, 1:30, Mabel Smyth Building.
- House of Delegates*, Saturday morning, 8:30, Mabel Smyth Building.

### SOCIAL PROGRAM

- Cocktail Dinner Dance*, Saturday evening, Oahu Country Club.
- Golf Tournament*, Sunday morning, Waialae Golf Club; Frank C. Spencer, M.D., in charge.
- Picnic*, Sunday afternoon, 12:00, Home of Dr. R. B. Cloward, 3787 Diamond Head Road.
- Picnic for Women Doctors only*, 2:30, Home of Dr. Marie K. Faus, 237 Portlock Road.

### NOTES

Scientific papers presented have been submitted for publication in the HAWAII MEDICAL JOURNAL.

The Art Exhibit was won by Dr. P. S. Irwin.

The Golf Tournament was won by Dr. C. C. McCriston.

### PROCEEDINGS

The minutes of meetings and reports follow:

### MINUTES OF MEETING COUNCIL

**Thursday, May 1, 1952 at 8:00 P.M.**  
**Mabel Smyth Building**

*Present*: Dr. Harry L. Arnold, Jr., presiding; Drs. McArthur (Maui), Tilden, Chung-Hoon, Wade (Kauai), Richard K. C. Lee, Ito and also Dr. Walsh.

*Adding Machine*: Approval was requested for purchase of an adding machine for the Association's office.

**ACTION: On motion of Dr. Tilden and seconded by Dr. Lee, the Council unanimously approved the purchase of the second-hand adding machine for \$76.88.**

*Annual Meeting Expense*:

**ACTION: Dr. Ito moved, seconded by Dr. Lee, that the amount of \$19.00 which will cover Dr. Harry Arnold, Jr.'s expenses at this annual meeting of the Association be given to him as a slight token of appreciation for his services as JOURNAL Editor. Motion was unanimously passed.**

*Journal Editorial Board*: The Council agreed that the following doctors should be added to the Editorial Board as Associate Editors in place of Dr. Pete Okumoto, Dr. Edward Kushi and Dr. C. H. Ishii: Drs. R. Yamanoha (Hawaii), Peter Kim (Kauai) and Edmund Tompkins (Maui).

Dr. R. J. McArthur, the new President of the Association, will be added to the Advisory Board. The other members will continue to serve.

Dr. Walsh suggested that some other doctor should be trained in the Editorial work of the JOURNAL so that he might possibly assume the editorship at some future date if for any reason Dr. Arnold's services might no longer be available.

**ACTION: On motion of Dr. Ito, seconded by Dr. Chung-Hoon, the Council recommended that the Editorial Board be enlarged by one or two members at the discretion of the President and that these new Associate Editors be approved.**

**Budget:** The budget for the fiscal year 1952-53 was discussed, particularly with reference to the Medical Library.

**ACTION:** It was moved by Dr. Lee, seconded by Dr. McArthur, that the Territorial Medical Association contribute \$100 to the Medical Library at this time. If at the end of the fiscal year, the balance on hand will enable the Association to increase the sum by an additional \$400, it will be done at that time. The motion was unanimously passed.

**ACTION:** On motion of Dr. Wade, seconded by Dr. Tilden, the Council unanimously accepted the budget with this reservation. It was recommended that the new President and Mrs. Bennett compile a job analysis, setting forth duties and responsibilities of the office staff, with personnel policy.

**National Society for Medical Research:** This is an organization which attempts to promote public understanding of medical research. Dr. A. J. Carlson is President and Dr. A. C. Ivy is Secretary-Treasurer. It is a federation of about two hundred organizations concerned with medical progress. The Territorial Medical Association has been invited to become a member organization. There are no dues. It is supported by contributions from its member groups.

**ACTION:** On motion by Dr. Lee, seconded by Dr. Wade, the Council voted to accept membership in the National Society for Medical Research and to contribute \$25 from the Miscellaneous Expense Fund.

**Auditors:** Dean and Paris had audited books of the Territorial Medical Association, Honolulu County Medical Society, Library and the Library Endowment Fund for more than eight years. The Council thought it would be advisable to secure new auditors in the hope of cutting down on the expense for this item and because it seemed advisable to have someone else check on the books.

**ACTION:** Dr. Lee moved that Robinson and Rhys, Robert Smelker and one other auditor be invited to look over the books and give an estimate on the cost of auditing, and that the new Treasurer of the Territorial Medical Association be authorized to employ the auditor whom he rates as the most suitable. The motion was seconded by Dr. Tilden and passed.

**Minutes:** Dr. Arnold stated that the minutes of the last Council meeting had been circulated and no corrections had been received.

**ACTION:** Dr. Chung-Hoon moved that the minutes of the Council Meeting of January 24, 1952 be approved as circulated. The motion was seconded by Dr. Lee and passed.

**Committees:** Dr. McArthur asked the Council for advice in appointing new committees. The Council suggested that a plan be formulated for staggering the term for committee members to provide for continuity. This has been done in the case of the Advisory Committee to the Bureau of Maternal and Child Health and the Advisory Committee to the Bureau of Crippled Children. It was recommended that the President and President-elect consult together concerning such committee appointments.

There being no further business the meeting was adjourned at 10:20 p.m.

I. L. TILDEN, M.D.  
Secretary

## HAWAII TERRITORIAL MEDICAL ASSOCIATION BUDGET

	1949-1950	1950-1951	1951-1952	BUDGET 1952-1953
<b>INCOME</b>				
Dues.....	\$ 7,380.00	\$ 9,475.00	\$ 9,487.50	\$ 9,600.00
Journal Advertising.....	7,480.93	7,454.32	8,047.84	8,575.00
Journal Subscription.....	2,275.50	2,446.50	2,424.47	2,425.00
Annual Meeting.....	2,128.34	904.07	2,281.52	2,000.00
Interest.....	8.46	30.60	30.90	31.00
Miscellaneous.....	125.27	94.36	168.41	175.00
	\$19,398.50	\$20,404.85	\$22,440.64	\$22,806.00
<b>EXPENSE</b>				
Journal Costs.....	\$ 8,411.29	\$ 9,099.38	\$ 8,968.89	\$ 9,875.00
Auditing.....	75.00	75.00	75.00	85.00
Postage.....	392.72	224.36	222.05	275.00
Rent.....	840.00	900.00	900.00	900.00
Salaries.....	6,253.44	7,538.75	6,894.23	8,050.00
Supplies.....	99.95	169.76	120.43	175.00
Taxes.....	57.78	97.73	204.75	115.00
Telephone & Cable.....	152.73	166.25	203.02	250.00
Travel.....	193.73	54.32	100.00	175.00
AMA Convention <sup>1</sup> .....	800.00	1,761.20	2,192.27	2,250.00
Medical Library <sup>2</sup> .....	.....	200.00	500.00	100.00
Equipment.....	.....	.....	.....	150.00
Council Expense.....	.....	.....	.....	135.00
Miscellaneous.....	85.75	114.25	252.36	270.00
	\$17,362.39	\$20,401.00	\$20,633.00	\$22,805.00

<sup>1</sup> Only \$62.52 was actually spent by Dr. Arnold, Jr., for his visits to the neighbor islands during his term of office, but since he did not complete his trips until after the close of the fiscal year February 29, 1951, we kept the budgeted amount of \$100.00 in reserve to cover whatever his expenses might be.

<sup>2</sup> The item budgeted for AMA Convention this year includes two round trips to Chicago in June plus \$400 for delegate's and alternate's expenses in June and one round trip to Denver plus \$175 for expenses at the interim session.

<sup>3</sup> In 1949-50 we gave the Medical Library \$550.00 in journals and \$576.75 in books. Total \$1,126.75.

In 1950-51 we gave the Library \$449.50 in journals and \$711.00 in books plus \$200 cash. Total \$1,360.50.

In 1951-52 we gave the Library \$557.25 in journals and \$850.70 in books plus \$500 in cash. Total \$1,907.95.

## MINUTES OF MEETING HOUSE OF DELEGATES

Friday, May 2, 1952, at 1:30 P.M.

Mabel Smyth Building, Honolulu, Hawaii

**Present:** Dr. Harry L. Arnold, Jr., presiding; Drs. Walsh, Burden (Maui), Tilden, Chung-Hoon, T. David Woo (Hawaii), Steuermann (Hawaii), Robert Benson, Burgess, Felix, Freeman, J. Lam, Cushnie, Vasconcellos, West, Choy, Wiig, Kaneshiro, Wallis (Kauai), Wilkinson (Maui County) and Toney (Maui).

Dr. Arnold announced that this was the meeting of the interim session of the House of Delegates which is required to be held approximately six months after the annual meeting. The Chair ruled that this was approximately six months after the last annual meeting.

**ACTION:** On motion of Dr. Felix, seconded by Dr. Tilden, the meeting was adjourned.

## HOUSE OF DELEGATES MEETING

Friday, May 2, 1952, at 1:35 P.M.

**Present:** Same delegates as at preceding meeting.

The Chairman called to order the annual meeting of the House of Delegates. The following reports were presented:

County Society Reports:

Kauai County Medical Society.....Dr. S. R. Wallis  
Honolulu County Medical Society.....Dr. William M. Walsh  
Maui County Medical Society.....Dr. J. Alfred Burden  
Hawaii County Medical Society.....Dr. T. David Woo

Officers' Reports:

Secretary—Dr. I. L. Tilden  
Treasurer—Dr. Edwin K. Chung-Hoon (read by Dr. Tilden)



The Chairman declared that the floor was open for nominations in addition to those which have been circulated. He stated that there will be further opportunity for nominations at tomorrow's meeting. No nominations were made.

**ACTION:** On motion of Dr. Wallis, duly seconded, the meeting was adjourned.

I. L. TILDEN, M.D.  
Secretary

## SUMMARY OF ACTIVITIES OF THE KAUAI COUNTY MEDICAL SOCIETY

Clyde H. Ishii, M.D., Secretary

The Kauai County Medical Society holds its monthly meetings at the G. N. Wilcox Memorial Hospital Library, Lihue, Kauai, on the second Wednesday of each month at 7:30 p.m. There are 13 members.

Dr. Nicholas Steuermann has secured a position at the Olaa Plantation in Hawaii. Succeeded by Dr. Clyde H. Ishii as Secretary-Treasurer.

Dr. Y. Kim, newly appointed resident physician at the G. N. Wilcox Memorial Hospital, replacing Dr. F. Sykes. Dr. Kim was formerly general practitioner in Honolulu.

Dr. Donald Chisholm, formerly of Mahelona Hospital, was made an honorary member of the Kauai County Medical Society.

Dr. Peter Kim has been made a member of the Society. He also replaced Dr. D. Chisholm of Mahelona Hospital.

The proposed amendment to the Constitution and By-Laws—Article IX of the By-Laws. The announcement is made as follows: In accord with Article IX of our Constitution and By-Laws. The following amendment is proposed to take effect immediately after adoption.

Amendment No. I, Article II, Section I, of the Constitution be changed to wit: the word Wednesday be deleted and changed to read Tuesday.

Voting on this amendment will take place at the next monthly meeting.

Election of officers was held at the March 12 meeting.

## SUMMARY OF ACTIVITIES OF THE HONOLULU COUNTY MEDICAL SOCIETY

C. M. Burgess, M.D., Secretary

The Honolulu County Medical Society had an interesting series of postgraduate lectures presented by Drs. Herbert F. Traut of San Francisco and Nicholas J. Eastman of Baltimore, eminent men in the field of obstetrics and gynecology.

There were two departures from the usual membership meetings. One meeting was sponsored by the Tripler Army Hospital Staff while the other, but with the omission of scientific papers, was held at the Oahu Country Club. One hundred forty-four members attended the latter meeting, which is believed to be somewhat of a record as to meeting attendance.

To help relieve night and absentia calls, the Public Service Committee, with the cooperation of the Nursing Service Bureau, instituted a Medical Emergency Call System. This system has been received by the public as

a very efficient step toward the improvement of our public relations. There are difficulties to be corrected such as the zoning of calls, poor response and often times a conflict of opinion; however, as a whole it is working out quite well.

The Fee Adjustment Committee is to be commended for their untiring efforts, for on April 1, 1952 the Industrial Accident Fee Schedule, with its increased rates, took effect. In addition to this, the new HMSA Fee Schedule, which was submitted by this Committee and approved by the Board of Governors, took effect on May 1.

A major accomplishment during the past year was the preparation and adoption of a new contractual agreement between the Honolulu County Medical Society and the Hawaii Medical Service Association. This contract replaces the loose agreement which has been more or less in effect since the organization of HMSA.

*Unfinished Business:* The execution of the Agreement between the Honolulu County Medical Society and its individual member physicians.

## SUMMARY OF ACTIVITIES OF THE MAUI COUNTY MEDICAL SOCIETY

Edmund Tompkins, M.D., Secretary

During the past year, twelve regular monthly dinner meetings were held, and one special Sunday breakfast meeting. These were all well attended by the members. The Society has been especially fortunate in having guest speakers for all the meetings, which stimulated more interest among the members.

Some of the activities during the year included:

1. An active participation in the immunization program for typhoid and tetanus. For the period during this drive, the required injections were given by all the physicians at a very reduced rate, which resulted in a good public response.
2. Considerable work has been done in trying to obtain a resident pathologist for the island. Funds are available and facilities have been planned for in the new Central Maui hospital for a pathologist. It is felt that such a person would be of distinct benefit to all the hospitals as well as to the practicing physicians in the County.
3. The Society has cooperated and urged the members to cooperate individually with the new Medical Indigent plan. Thus far, it has seemed to work out quite successfully in Maui County.
4. The Society went on record to continue to indorse and support the HMSA.

The new officers elected for the coming year are: Dr. J. Alfred Burden, President; Dr. Harold Kushi, Vice-President; Dr. Edmund Tompkins, Secretary and Treasurer.

## SUMMARY OF ACTIVITIES OF THE HAWAII COUNTY MEDICAL SOCIETY

Richard A. Yamanoha, M.D., Secretary

Twelve regular monthly meetings were held during the fiscal year. No special meeting was called.

Our elected Disaster Council is composed of Drs. Leo Bernstein, Walter Seymour, Clarence Carter, Howard Crawford, and S. Kasamoto.

Resolution expressing the Society's deepest regret at the death of Dr. John Milford was read and adopted.

An Amendment to the Constitution and By-Laws decreasing the quorum to ten members was passed unanimously.

## REPORT OF THE SECRETARY

I. L. Tilden, M.D.

The total membership of the Association in all classes is 509, of which 384 (4 more than last year) are paid regular members. By counties this membership is made up as follows:

	REG- ULAR	ASSO- CIATE	RETIRED	LIFE	HONO- RARY	TOTAL, ALL CLASSES
Hawaii.....	38	....	....	....	1	39
Honolulu.....	306	94	4	11	11	426
Kauai.....	13	....	....	....	2	15
Maui.....	27	....	....	....	2	29
	384	94	4	11	16	509

The total number of physicians licensed to practice medicine in the Territory of Hawaii as of March 31, 1952, is 601. Of this number 452 are now residing in the Territory. Of these 425, or approximately 94 per cent, belong to the Hawaii Territorial Medical Association.

## REPORT OF THE TREASURER

E. K. Chung-Hoon, M.D.

Mr. President and Members of the  
Hawaii Territorial Medical Association:

The Association's financial status is sound and secure. We budgeted \$20,885.00, had an income of \$22,440.64, spent \$20,633.00 and realized a net gain of \$1,807.64.

During the past 3 years our financial report was briefly as follows:

	1949-1950	1950-1951	1951-1952
Income.....	\$19,398.50	\$20,404.85	\$22,440.64
Expenditures.....	17,362.39	20,401.00	20,633.00
Net Gain.....	\$ 2,036.11	\$ 3.85	\$ 1,807.64

The Association's cash balance as of March 1, 1952 is \$10,334.78. Of this sum \$3,083.55 is in a savings account, \$7,201.23 is in a checking account, and \$50.00 is in a petty cash fund. Though the association is not a profit-making organization it must have a comfortable margin of cash assets to operate successfully. The annual convention for 1953 will be on a neighbor island, Maui, and it is not anticipated that the income from that convention will be as great, and therefore some of the surplus funds will be required to finance next year's operation. IT IS RECOMMENDED THAT there be no reduction of membership dues at this time.

The Public Service Committee had a cash balance of \$1,693.19 on March 1, 1951 and during the past year spent \$73.25 leaving a residual of \$1,619.94 on March 1, 1952. There was no income.

One of the main functions of the Hawaii Territorial Medical Association is the publication of the HAWAII MEDICAL JOURNAL. The publishers have served notice that they are obliged to increase charges for publishing the JOURNAL. It might be noted that the publishers had not raised their charges over the past 6 years even though costs have risen considerably.

It must be borne in mind that the association does not pay the Editor for his services. Through the years Dr.

Harry L. Arnold, Jr., has given generously of his time, his efforts and his many talents to the publication of the HAWAII MEDICAL JOURNAL. The association owes a debt of gratitude to Dr. Arnold for a job well done. IT IS RECOMMENDED THAT, in behalf of the association, the secretary be instructed to write a letter of appreciation to Dr. Arnold for his untiring efforts and splendid work as Editor.

The following table portrays the financial report in detail:

	ACTUAL EXPENDITURE			BUDGET
	1949-1950	1950-1951	1951-1952	1952-1953
INCOME				
Dues.....	\$ 7,380.00	\$ 9,475.00	\$ 9,487.50	\$ 9,600.00
Journal Advertising..	7,480.93	7,454.32	8,047.84	8,575.00
Journal Subscription	2,275.50	2,446.50	2,424.47	2,425.00
Annual Meeting.....	2,128.34	904.07	2,281.52	2,000.00
Interest.....	8.46	30.60	30.90	31.00
Miscellaneous.....	125.27	94.36	168.41	175.00
	\$19,398.50	\$20,404.85	\$22,440.64	\$22,806.00
EXPENSE				
Journal Costs.....	\$ 8,411.29	\$ 9,099.38	\$ 8,968.89	\$ 9,875.00
Auditing.....	75.00	75.00	75.00	85.00
Postage.....	392.72	224.36	222.05	275.00
Rent.....	840.00	900.00	900.00	900.00
Salaries.....	6,253.44	7,538.75	6,894.23	8,050.00
Supplies.....	99.95	169.76	120.43	175.00
Taxes.....	57.78	97.73	204.75	115.00
Telephone & Cable...	152.73	166.25	203.02	250.00
Travel.....	193.73	54.32	100.00	175.00
AMA Convention.....	800.00	1,761.20	2,192.27	2,250.00
Medical Library.....	.....	200.00	500.00	100.00
Council Expense.....	.....	.....	.....	135.00
Equipment.....	.....	.....	.....	150.00
Miscellaneous.....	85.75	114.25	252.36	270.00
	\$17,362.39	\$20,401.00	\$20,633.00	\$22,805.00

In conclusion I wish to extend my sincere thanks and appreciation to the Executive Secretary, Mrs. Edith Bennett, for her kind assistance throughout my tenure of office and for her splendid management of the association's business. I wish also to express my appreciation to Mrs. Florence Gray who, until recently, was acting executive secretary during Mrs. Bennett's leave of absence, and Miss Florence Isoda, secretary-clerk, for her superb bookkeeping and for her cheerful and efficient performance of duty.

## MINUTES OF MEETING HOUSE OF DELEGATES

Saturday, May 3, 1952, at 8:30 A.M.  
Mabel Smyth Building, Honolulu, Hawaii

*Present:* Dr. Arnold, Jr., presiding; Drs. Walsh, Burden (Maui), Tilden, Chung-Hoon, Woo (Hawaii), Robert Benson, Burgess, Cushnie, Durant, Samuel Yee, Dodge, Felix, Freeman, Takeo Fujii, Joseph Lam, Vasconcellos, West, Choy, Wallis (Kauai), Wilkinson (Maui) and Toney (Maui).

*Committee Reports:* Reports of the following committees were read and placed on file:

Legislative Committee—Dr. Samuel L. Yee  
Diabetes—Dr. Morton E. Berk  
Tuberculosis—Dr. H. H. Walker  
HAWAII MEDICAL JOURNAL—Dr. H. L. Arnold, Jr.  
Public Service—Dr. Isaac A. Kawasaki  
Postgraduate—Dr. Verne C. Waite  
Woman's Auxiliary—Mrs. Robert Johnston  
Board of Management, Mabel Smyth Building—Dr. Rodney West  
Health Education—Dr. Tell Nelson  
By-Laws—Dr. F. D. Nance  
Advisory Committee to the Bureau of Crippled Children—  
Dr. J. Warren White  
Chronic Illness—Dr. Shoyei Yamauchi  
Advisory Committee to the Bureau of Maternal and Child Health  
—Dr. Duke Cho Choy  
Cancer—Dr. Grover A. Batten  
Emergency Medical Service—Dr. R. B. Faus



*Hawaii Medical Journal:* Dr. Arnold, Jr.'s report contained a recommendation that the Editorial Board should have a chairman other than the Editor, whose duty it should be to convene the Board when occasion requires and to make the annual report; and further recommended that the continued publication of the HAWAII MEDICAL JOURNAL be authorized, on the same basis as heretofore, for the coming year.

**ACTION:** On motion of Dr. Freeman, seconded by Dr. Vosconcellos, the recommendations were approved. It was understood the Editor would be an ex-officio member of the Editorial Advisory Board. The chairman would be selected by the group itself.

*Public Service:* Dr. Yee asked about using the Public Opinion Survey made in Honolulu the previous year. He was assured this had been used as a basis for the work of the Public Service Committee.

**ACTION:** On motion of Dr. Cushnie, duly seconded and passed, it was agreed that the Public Service Committee report should be sent to each County Society for its opinion, these recommendations to be correlated by the President.

Dr. Durant reminded the House of Delegates that some steps should be taken to assure the Public Service Committee of adequate funds to carry on.

There was considerable discussion about the use of doctors' names in the press and on the radio.

*Postgraduate:* It was recommended that the Post-graduate Committee arrange for Honolulu doctors to visit other islands, as well as for mainland doctors to come to Hawaii.

*Mabel Smyth Building:* Dr. West mentioned that plans have been drawn up by Merrill, Simms & Roehrig for an addition to the building costing about \$55,000 to \$60,000.

Dr. West also said that Miss Jessie Eyman, manager of the Mabel Smyth Building, will retire May 31. An Aloha Tea has been planned for Miss Eyman at which she will be given a gift by the organizations having space in the building.

**ACTION:** On motion of Dr. West, seconded by Dr. Yee, it was voted to give \$25.00 from the Territorial Medical Association toward a gift for Miss Jessie Eyman.

*Health Education:* Dr. Nelson's report outlined plans for a proposed weekly half hour radio program on KGMB with Larry Stevens. The doctors would participate in a question and answer program on child health and related topics.

In this connection, the chairman read a letter from Dr. Isaac Kawasaki, chairman of the Public Service Committee, asking the House of Delegates to adopt a policy regarding the use of doctors' names in the newspaper and on the radio program.

**ACTION:** It was moved by Dr. Durant, seconded by Dr. Cushnie, that the House of Delegates approve the use of doctors' names in connection with the proposed KGMB radio program. The motion was passed with no dissenting vote.

**ACTION:** The specific radio project, as outlined by Dr. Nelson, was unanimously approved, on motion of Dr. Durant, seconded by Dr. Burden.

*By-Laws:* Copies of Dr. Nance's report on proposed revision of the Constitution and By-Laws had been circulated to all Delegates for study. The chairman reminded the Delegates that any definite amendments

could not be passed until the 1953 annual meeting, but that recommendations would be considered at this time.

#### A. SUGGESTED CHANGES IN CONSTITUTION ARTICLE I. NAME.

**ACTION:** On motion of Dr. West, seconded by Dr. Freeman, it was recommended that the name of the Association be changed to "HAWAII MEDICAL ASSOCIATION."

#### ARTICLE VI, Paragraph 4.

Dr. Nance suggested inserting "This function may never be exercised by the Council" after the third sentence to make it clear that the Council may not expel an officer of the Association or a member of the Council. This was accepted without discussion.

#### B. SUGGESTED CHANGES IN BY-LAWS CHAPTER I. Section 8. Election of delegates.

**ACTION:** On motion of Dr. West, seconded by Dr. Burden, it was recommended that no change be made in the present method of selection of delegates and alternates to the H.T.M.A.

#### CHAPTER III. Officers.

**ACTION:** On motion of Dr. Walsh, seconded by Dr. Vosconcellos, the Delegates approved the principle that the president-elect should be an active, voting member of the Council and House of Delegates and first vice-president.

**ACTION:** On motion of Dr. Freeman, seconded by Dr. Walsh, it was recommended that the secretary and treasurer be elected in alternate years for two year terms.

#### CHAPTER V. The Council.

**ACTION:** On motion of Dr. Vosconcellos, seconded by Dr. Walsh, it was recommended that there be no change in the provision that "No councillor shall serve for more than two consecutive terms or a maximum of three terms."

#### CHAPTER VI. Meetings.

**ACTION:** On motion of Dr. Tilden, seconded by Dr. Burden, the Delegates recommended that Section 3, paragraph A, be changed to read, "There shall be interim sessions of the House of Delegates if and when circumstances make such a session necessary. Such session will be called either by the President on his own initiative or when he receives written requests for such a meeting from three or more members of the House of Delegates."

#### CHAPTER VII. Election of Officers.

**ACTION:** On motion of Dr. Walsh, seconded by Dr. Tilden, the Delegates recommended that Section 3, "Any person known to have solicited votes for or sought any office within the gift of the Association shall be ineligible for any office" should be deleted.

#### CHAPTER IX. Miscellaneous.

**ACTION:** On motion of Dr. Vosconcellos, seconded by Dr. Burgess, the Delegates approved the recommendation that the phrase in Section 1 now reading "no member shall speak longer than five minutes, nor more than once, on any subject except by unanimous consent" should be changed to read "nor more than twice on any subject, except by unanimous consent."

A suggestion also had been made that the Council be abolished in its present form and some other form of executive board be substituted, but no recommendation was made on this point.

*Chronic Illness:* Dr. Yee felt that Dr. Yamauchi's committee should be commended for their work. The committee report made two recommendations:

1. That the Territorial Medical Association request the Governor to form a Commission on Chronic Illness, and
2. That the Territorial Medical Association strengthen the present Advisory Committee by setting up a "Committee on Chronic Illness" for each County Medical Society with a representative on the Territorial Advisory Committee.

There was some discussion on asking the Governor to form a commission. Dr. Yee suggested that possibly this could be a subcommittee of the Commission on Hospital and Medical Care.

**ACTION:** On motion of Dr. Vasconcellos, seconded by Dr. Walsh, the Delegates approved of enlarging the Chronic Illness Committee and having county committees also as proposed in the report.

**ACTION:** Dr. Vasconcellos moved that we oppose the formation of a Governor's Commission and encourage the enlarged committee to make further studies. The motion was seconded by Dr. Felix and unanimously passed.

*Crippled Children:* The recommendations in the report of the Advisory Committee to the Bureau of Crippled Children were considered, but the Delegates felt they did not have sufficient information to act on them. On motion duly made, seconded and passed, the report was tabled.

*HMSA:* Dr. Faus told of recent developments in HMSA.

**ACTION:** On motion of Dr. Wallis, seconded by Dr. Toney, a general endorsement of the policies and practices of HMSA was passed.

*Budget:* The budget for 1952-53, which had been approved by the Council, was circulated to the Delegates.

**ACTION:** On motion of Dr. Wallis, seconded by Dr. Cushnie, the budget was approved.

*Industrial Accident Fee Schedule:* A resolution to make the Industrial Accident Fee Schedule of the Honolulu County Medical Society the official Industrial Accident Fee Schedule of the Hawaii Territorial Medical Association had been circulated to the Delegates. Dr. Wallis had also suggested that one member of the Fee Adjustment Committee be designated to keep the Medical Societies on the neighbor islands informed. The disadvantages of making the fee schedule territorial were stated. Dr. Richert, chairman of the Fee Adjustment Committee, stated that it was their present intention to print on the fly leaf of the fee schedule "Adopted by the Hawaii, Kauai and Maui County Medical Societies."

**ACTION:** On motion of Dr. Woo, seconded by Dr. Toney, the resolution was abandoned.

*Dinner Meetings of Council:* The chairman said that a dinner meeting was the most convenient time for the Council to meet because of the Council members coming from the other islands. The Council had voted to pay for dinner meetings from the Territorial Association funds.

**ACTION:** On motion of Dr. Yee, seconded by Dr. Felix, the Delegates approved of charging Council meeting dinner expenses to the Territorial Association.

*1953 Annual Meeting:* It was agreed that the annual meeting in 1953 should be held from April 30 through May 3 on the Island of Maui with a registration fee of \$10.00.

*Election:* Nominations by the Nominating Committee (Dr. Douglas Bell, chairman) had been circulated as follows:

President-Elect.....	Dr. Edwin K. Chung-Hoon
Secretary (3 years).....	Dr. Leslie Vasconcellos,
	Dr. Samuel L. Yee
Treasurer (3 years).....	Dr. Thomas H. Richert,
	Dr. Laurence M. Wiig
Councillors (3 years)	
From Kauai.....	Dr. K. K. Fujii
From Maui.....	Dr. Joseph E. Ferkany,
	Dr. John F. Sanders

The chairman called for nominations from the floor but none were made.

**ACTION:** On motion of Dr. Durant, duly seconded, the nominations were closed.

While the ballots were being counted, Dr. Joseph Lam said that it has been the custom to meet every third year on an outside island. He asked consideration of the advisability of having the meeting every other year on another island. The Delegates felt the present system was more satisfactory.

Because of the length of time occupied in reading annual reports, it was recommended that such reports be mimeographed and circulated prior to the meeting.

The results of the election were as follows:

President-Elect.....	Dr. Edwin K. Chung-Hoon
Secretary.....	Dr. Samuel L. Yee
Treasurer.....	Dr. Thomas H. Richert
Councillors.....	Dr. K. K. Fujii
	Dr. John F. Sanders

There being no further business, the meeting was adjourned.

I. L. TILDEN, M.D.  
Secretary

## REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF TUBERCULOSIS

H. H. Walker, M.D., Chairman

There were no meetings of the Committee held during this past year and, accordingly, the Committee has no recommendations to make at this time.

## REPORT OF THE HAWAII MEDICAL JOURNAL

Harry L. Arnold, Jr., M.D., Editor

The last 6 issues of the JOURNAL have averaged 72 instead of 82 pages as in the preceding 6, with the same ratio of letterpress to advertising pages (13 to 1). JOURNAL income (subscriptions and advertising) increased from \$9,901 to \$10,472 in this fiscal period, and printing costs dropped from \$9,099 to \$8,968. With an increase in value of exchange subscriptions and review copies of new books from \$1,360 to \$1,908, the JOURNAL showed a net profit for the year of \$3,411 as opposed to \$2,162 last year. This is not, of course, nearly large enough to cover the salary costs necessitated by this phase of our Association's operations; we are in the process of trying to make a fair estimate of this at the present time. Moreover, it will be less next year because of a just-announced increase in printing costs, the first



increase we have had since the Star-Bulletin began printing the JOURNAL over 6 years ago. However, we are also planning a more intensive campaign for the solicitation of local advertisements, and this is expected to improve our financial position considerably. No increase is planned in subscription rates, sensible and reasonable though this would appear to be, because we fear it might reduce our circulation among the nurses and thereby lower our advertising rates.

A regular page has been donated for use by the HMSA in each issue starting with the January-February one this year. A regular feature entitled Umi Makahiki I Hala (Ten Years Ago) was begun with the first issue of Volume 11, and it has proven very popular: 3 physicians are known to have read one or more instalments of it to date.

We are not receiving enough papers for publication to keep ahead of our publishing schedule or to permit us to exercise much judgment in selecting contributions. By publishing all that is submitted, we have been able to keep about even, and that's all. The current issue (as this is written) contains two request articles and a requested guest editorial, and it is anticipated that more material of this sort may prove a good way out of this difficulty.

I should like to commend Mrs. Florence Gray, who acted as Managing Editor during Mrs. Bennett's 8 months' absence this year and did an excellent job of it. Your Editor had to get his hands back onto the galley proofs and scissors, and into the rubber cement, just enough to remind him of how much work Mrs. Bennett regularly does on the JOURNAL, and how quietly and well she does it—namely, *very*.

Dr. Lawrence Wiig felt compelled by pressure of other responsibilities to resign as News Editor, a position which he has held down most ably since 1948, and his place was taken by Dr. William John Holmes, the first of the two who volunteered for the job. Dr. Hastings Walker and Dr. Homer Izumi are continuing as the two members of the Advisory Editorial Board.

Your Editorial Board should, I believe, have a chairman other than the Editor, whose duty it should be to convene the Board when occasion requires and to make this annual report, and it is my recommendation that this be put into effect by the House of Delegates at this time. It is my further recommendation that the continued publication of the HAWAII MEDICAL JOURNAL be authorized, on the same basis as heretofore, for the coming year.

## REPORT OF THE PUBLIC SERVICE COMMITTEE

**Isaac A. Kawasaki, M.D., Chairman**

On the basis of a study of our last year's survey, it is our opinion that the primary public complaint is really the fault of the doctor and office staff. Such things as long waiting room hours, curt and cold manner of the office—and don't forget our own families—of telephone and night call answers, are those factors which are thorns in the side of the public. It is suggested that we may be able to sponsor a public relations course for our own office help. This course can be given by some of our own members or even a hired public relations man.

To help solve the night and absentia calls we have instituted the emergency call system. As a whole it has

been received by the public as a very efficient step toward good public relations. There are isolated cases, as expected, of poor response and some conflict of opinions, but as a whole it is still working well. It is felt that frequent advertisement of this service will keep this good will alive.

Another step to good public relations is good public information and education. Toward this goal the committee, in conjunction with the Health Education Committee of Dr. Tell Nelson, met with the representatives of the press for an informal gathering. The bill for this entertainment was footed by every committee member and not by the Society as a whole. The results are better mutual understanding of our problems by the press. As you have already noticed, there are frequent articles of our professional activities in the daily papers which will in the long run awake our public to the fact that we do not have to take second place to any other medical center. It is suggested that the next committee keep this good relation alive by more meetings with the press and radio. The bill for the entertainment is their problem as it was ours.

The problem of malpractice insurance occupied some time for investigation. In our opinion this problem is not quite settled. There are several factors to consider. Basically, the faulty comments by physicians themselves or their hired help are the trigger mechanisms for legal suits. There is the basic weakness of our profession from bad publicity and consequent deleterious effect on our practice of medicine. Are we to take a 300 per cent increase in insurance rates without some organized effort to remedy it? We know that it is useless to argue with the insurance companies. On the other hand, they can argue with us on our plea to increase our fee schedule for compensation cases. The legal profession is also out of the question. They will not cooperate since it is their own livelihood. We feel that we, as an organized group, can remedy some of the causative factors. First, we ought to control our own opinions of cases done by others. Second, we ought to go to the aid of any of our members involved in legal suits and see if expert opinions can be given to aid in a legal fight for our own colleague rather than to subject him to being an easy target for out of court settlements and hence easy income for the legal profession. Lastly, the simplest step of all, we can make a list of those people who have brought suits against the medical and dental profession and give this list to all our members as a so-called "caution list." Then it is up to us to either take the case or refuse to handle a "hot" case. We feel also that since the rates of malpractice insurance here are so much higher than on the mainland and that since these rates are set by the insurance rating board, therefore if an entire organization like ours and the dental society might approach some other insurance concern there is a great possibility that some company might withdraw from the rating bureau and set their own mainland company fees. This has occurred to a group of dentists locally, but the number of these men was too small to have made it worthwhile for the company to take such a step as to withdraw from the rating bureau.

I wish to extend my deepest appreciation to Drs. Allison, Arnold, Jr., Casey, Nishigaya, L. Q. Pang and Richert for their brilliant cooperation and ideas. This is the combined Territorial and County Public Service Committee. I also wish to thank Dr. Tell Nelson, and his Committee for their great help.

## REPORT OF THE LEGISLATIVE COMMITTEE

**Samuel L. Yee, M.D., Chairman**

There being no problems or situations relating to legislation during the year, no meetings were held by the Legislative Committee.

The Chairman, because of informal conversation with others in the community, recommends that there be a close cooperation among the other committees of like nature in the various organizations.

## REPORT OF THE POSTGRADUATE COMMITTEE

**Verne C. Waite, M.D., Chairman**

As in the past, functions of the Territorial Postgraduate Committee were concerned almost exclusively, because of the Honolulu County Postgraduate Committee, with assistance and advice to the outside island Postgraduate Committee members.

The plan of activities for the year was assembled rather early, at which time the Honolulu County Postgraduate Committee decided to withhold its expenditure of several thousand dollars for the purpose of bringing lecturers in the spring of 1952 for the following reasons:

- a. The coming conference of the Pan-Pacific Surgical Association would offer extensive postgraduate experiences for surgeons, obstetricians, gynecologists, and general practitioners, particularly, which would be rather varied and, of course, high degree in quality.
- b. We had already been informed that the Tuberculosis Association and the Cancer Society would each finance some mainland teacher for postgraduate lectures some time in the spring of 1952.

On the basis of the above principles, it was decided that the Society might well save money which had been expended in the past for this purpose.

This Committee placed itself at the disposal of the Committees of the Pan-Pacific Surgical Association and offered to render assistance when such was required. It is a matter of record that the Pan-Pacific Surgical Congress was a highly instructive and generally successful enterprise and certainly all physicians in the Territory were benefitted directly or indirectly by the format of its distribution.

The Honolulu Society continued as in previous years to benefit greatly by tourist physicians who discussed their particular subjects either at the County Society meetings or meetings of the various specialty groups. However, as in the past, attempts at persuading these visitors to render lectures while visiting on other Islands proved to be unsuccessful. In most instances, their visits to other Islands were brief and did not offer sufficient time or the individual concerned was not interested. To me, this is a serious defect in our distribution of postgraduate information; that is, the inability to reach the doctors on the outside Islands, and at the present time there seems to be no immediate solution. Attempts have been made at procuring Honolulu specialists. However, this has been unsuccessful in most instances, but might offer more hope if some means of subsidizing the traveling expenses of such specialists could be arranged.

In January, 1952, this Committee presented a list of suitable candidates as lecturers to both the local Cancer Society and the Tuberculosis Association, and although these groups were unable to procure the individuals recommended by the Committee, suitable teachers have

been obtained by them, and, of course, they will pay their expenses and the entire Society will have the opportunity of hearing these teachers at about the time of our annual meeting.

During the course of the year, letters were written to the deans of all Class A medical schools in the United States advising them that when members of their staff tour through Hawaii, we would be pleased to have them discuss a favorite subject at our meetings. Answers from all of these inquiries were received, and it is believed that in the future we may have more notice regarding the arrival of outstanding medical men.

By way of recommendations for the coming year, I would, again, suggest that some means and procedure be established which would permit the organization of a definite series of postgraduate lectures, seminars, and clinics on the outside Islands to be conducted by specialists or qualified individuals from Honolulu. However, some means for payment of their expenses should be devised by either the Territorial Association or by the County Society involved. Further, since the funds of the Society earmarked for postgraduate purposes are somewhat limited, it is suggested that so long as the local Cancer Society and the Tuberculosis Association will continue to bring outstanding teachers to the Territory, we should limit the use of our own funds for purposes of the postgraduate lecture series each spring. Perhaps the Society should finance the expense of one additional teacher during the year, preferably someone other than a surgeon or an internist, since one of these latter groups will usually be selected by the Tuberculosis or Cancer Societies.

The Committee at its final meeting reviewed the volume of postgraduate opportunities that had been offered during the past three years. We wish to recommend that an internist, who can offer a series of lectures on diverse medical subjects, be brought to the Territory during the year 1952-1953.

This recommendation is offered in view of the fact that there has been an abundance of surgeons, obstetricians and gynecologists, and also due to the fact that there will be pathologists here during the current year.

## REPORT OF THE WOMAN'S AUXILIARY TO THE TERRITORIAL MEDICAL ASSOCIATION

**Mrs. Robert G. Johnston, President**

The officers for the year 1951-52 were:

President.....	Mrs. Robert G. Johnston
President-Elect.....	Mrs. Garton E. Wall
First Vice-President.....	Mrs. J. Warren White
Second Vice-President.....	Mrs. Henry B. Yuen
Recording Secretary.....	Mrs. K. S. Tom
Corresponding Secretary.....	Mrs. Teruo Yoshina
Treasurer.....	Mrs. Richard D. Kepner

Executive Board Members were:

Mrs. John W. Cooper	} hold over
Mrs. Lyle Phillips	
Mrs. Hastings H. Walker	
Mrs. Robert Millard	
Mrs. Francis J. Halford, past president	

There were six meetings held during the year. Of these, two were meetings of the Executive Board, two were meetings of the general membership, one was the House of Delegates' meeting on May second, and the annual meeting of the membership at large on the same date.



At the meeting of the general membership on September 11, 1951, Dr. Nils P. Larsen spoke on "The United World Federalists Organization." Reports were also given of the Woman's Auxiliary meeting in connection with the AMA meeting, in June 1951 at Atlantic City. Our representatives were Mrs. Frederick L. Giles, delegate, and Mrs. Peter Washko, alternate, who presented graphic reports of the convention and the activities of Auxiliaries throughout the country. At this first fall meeting it was a particular pleasure to welcome as guests wives of many of the Tripler Hospital staff.

Another regular membership meeting was held on January 29, 1952 to which members of the newly-formed Woman's Auxiliary to the Hawaii Territorial Dental Society and members of the American Association of University Women were invited as special guests. Following a social hour with refreshments, a transcription of the excellent speech on "Socialized Medicine" given by Dr. John W. Cline, President of the American Medical Association, to the Honolulu Chamber of Commerce at the time of the Pan-Pacific Surgical Congress, was presented. This was felt to be sound public relations as well as stimulating to our own group.

At the request of the Executive Board of the Pan-Pacific Surgical Society, the Auxiliary assisted in arrangements for the social program for the Pan-Pacific Surgical Congress in November, 1951. Events included the opening Cocktail-Supper Party at the Tripler Hospital Officers' Club, an International Tea at the Honolulu Academy of Arts, a Luau at the Waialae Country Club, as well as management of the Congress Information Desk at the Royal Hawaiian Hotel. This assignment constituted our major undertaking for the year. It is impossible to cite all the members who made the social program such a success, since Auxiliary members from all the Islands responded generously with their time and energy.

Special thanks are due in this connection to Mrs. Jay Kuhns, Auxiliary member-at-large from Kauai and to Mrs. Caroline E. Peterson of Honolulu who were responsible in large measure for making the decorations for the Luau particularly outstanding.

At the meeting of the House of Delegates on May 2 the following officers were elected for the coming year:

President.....	Mrs. Katsuyuki Izumi
President-Elect.....	Mrs. Garton E. Wall
First Vice-President.....	Mrs. Herbert Hata
Second Vice-President.....	Mrs. Frederick L. Giles
Recording Secretary.....	Mrs. John H. Peyton
Corresponding Secretary.....	Mrs. Guy S. Haywood
Treasurer.....	Mrs. Richard D. Kepner
Executive Board Members.....	{ Mrs. O. D. Pinkerton
	{ Mrs. Laurence G. Thouin

Mrs. Douglas Murray and Mrs. Garton E. Wall were elected as Delegates to the Auxiliary Meeting of the American Medical Association in Chicago in June, 1952.

I would like to thank at this time my local Executive Board and officers and also the Telephone Committee of the Honolulu County Auxiliary for their help on several occasions. To Mrs. Bennett and Mrs. Gray and others in the Medical Society office our appreciation for their continuing faithful assistance. Dr. John Devereux, Chairman of our Medical Advisory Board, was never too busy to discuss Auxiliary problems: to him a vote of thanks.

In conclusion, I know I speak for all Auxiliary members present when I express our gratitude to the Honolulu County Auxiliary under Mrs. Thomas F. Fujiwara

and her Committees for a very pleasurable Luncheon and Fashion Show today.

## REPORT OF THE DIABETES CONTROL COMMITTEE

**Morton E. Berk, M.D., Chairman**

This committee is in the process of organization and there is actually no report to be made at this time, except that we hope to have some kind of a program on a territory-wide basis this coming year. We were too late in starting our committee to be able to show any concrete results of our labors this year, except in the Honolulu County Medical Society.

## REPORT OF THE HEALTH EDUCATION COMMITTEE

**Tell Nelson, M.D., Chairman**

It is with pleasure that the following report of the activities of the Health Education Committee of the Hawaii Territorial Medical Association during the year 1951-1952 is presented. Your committee members, Drs. S. D. Allison, T. Alan Casey, Duke Cho Choy and Tadao Hata have served efficiently and well and have given valuable time and effort to the activities and work of the committee.

The program which was set up this year for accomplishment was based upon the recommendations made by your committee in its last annual report. Efforts have been made to put the recommendations into effect. However, all our goals have not been attained and there is still much to be done by future groups. It was felt by the committee that our main efforts should be centered around improving and establishing more intimate relationship with both the press and radio as a means of disseminating medical information of wide scope to our own people and by our local physicians and institutions. To this end two activities may be cited:

1. Press relations: In conjunction with the Public Service Committee a dinner meeting was held at which members of the local press were invited. Mutual problems affecting both the medical profession and the press were discussed. The meeting proved to be of great value in clarifying ideas and opinions about press releases relating to medical affairs. The cordial relationship and understanding established by this informal discussion should in the future be a great aid in an educational manner, in providing reliable information for the public through the medium of the press.

2. Radio relations: Within the past two months one of our local radio stations—KGMB—with outlet on the island of Hawaii, has offered through one of its well-known announcers to create and maintain a program for the dissemination of medical information to the public at *no cost* to our association. The essence of the project may be summarized as follows:

- a. A program of thirty minutes length is proposed to be broadcast once a week at a convenient hour.
- b. The program will be of the informal round table discussion type; that is, questions and answers, very similar to the many popular such programs now aired on the mainland.
- c. The financial sponsors will be obtained through the radio station and will be passed upon by the Medical Association prior to any release over the air. In other words, the Association will control the sponsorship which will be at *no cost* to the society. Programs will carry only an initial and closing an-

nouncement of the sponsor. Participating members of the medical profession will be introduced at the beginning of each broadcast as "doctors from the Territorial Medical Association."

- d. The program will be tape recorded days or even weeks in advance and at the collaborating physicians' convenience.
- e. Questions to be used will be submitted to the participating physicians several days prior to the recordings so that there will be ample time for formulating opinions and answers.
- f. Physicians who have signified their willingness to appear as guest speakers on the broadcast will be chosen from panels submitted by the various special societies such as the County Medical Societies, the Honolulu Academy of General Practice, the Pediatrics Society, Orthopedic Society, Dermatological Society, the Ear, Eye, Nose and Throat Society and others. It is stressed by your committee that this program should not be one primarily for the specialist but rather one for the family doctor—the general practitioner. It is therefore proposed that on each broadcast there be at least one man from the field of general practice and perhaps one from a special field. Physicians from outer islands are urged to participate whenever they are in Honolulu so that the project may be made Territory wide in its scope.
- g. It is proposed that the controlling body and clearing house for the broadcasts be made part of the duties of the Health Education Committee of the Hawaii Territorial Medical Association. The screening of subject matter to be discussed, the selection and approval of sponsorship and choosing of participating physicians for each broadcast should funnel through this committee.

County and special societies have been notified through the mail of the project which is expected to begin approximately June 15. The response to date has been most favorable and gratifying. Several lists have already been received of proposed participants from the special societies.

In view of the interest manifested in this program it is recommended that it be favorably considered by the members at large of the Hawaii Territorial Medical Association.

## REPORT OF THE BOARD OF MANAGEMENT MABEL L. SMYTH MEMORIAL BUILDING

Rodney T. West, M.D.

Members of the Board of Management for 1951 were: Mrs. Storme, chairman, Mrs. Ethel Brown, Dr. Ito, Mr. A. L. Y. Ward, representing the trustees of Queen's Hospital, and myself.

Since the Mabel L. Smyth Memorial Building is more than 11 years old it is beginning to need some repairs and replacements. The entire interior was painted this year at a cost of \$443. New Venetian blinds have been put in the medical library and the medical offices at a cost of \$379.60. Improvements have been made such as rearranging parking stalls, adding three more; installation of an inter-communication system on the first floor and lighting the rear of the building to discourage prowlers. A Steinway grand piano, \$1,846, has been purchased from funds raised mostly by the nurses.

A mail box service has been arranged and offered to health and welfare organizations which do not maintain an office. Some of the organizations have their telephone listings under "Mabel L. Smyth Memorial Building" and the others should be listed, in order to give a more efficient service.

A brochure is now available giving a short history of the building and services it can render the public.

The financial condition of the building is satisfactory. Income over all expenditures in 1951 was \$627.69. The budget for 1952 is \$11,412.50. Any help you can give towards promoting use of the auditorium by the public, will help our financial position.

All organizations having office space in the building complain about cramped quarters, especially the Medical Library—therefore it seems imperative that we enlarge the building to relieve this situation.

Replacements on the Board for 1952 are Mrs. Lois Bell replacing Mrs. Storme and Dr. J. Warren White replacing Dr. Ito. Any constructive criticism you may have to offer, will be received by the Board at any and all times.

## REPORT OF THE BY-LAWS COMMITTEE HAWAII TERRITORIAL MEDICAL ASSOCIATION

F. D. Nance, M.D., Chairman

The following recommendations are presented for your consideration:

### A. SUGGESTED CHANGES IN CONSTITUTION

*Article 1.* A return to the original name "The Hawaiian Medical Society" for three reasons: (a) It is short and euphonious. (b) It will not require change when statehood comes to Hawaii. (c) It perpetuates the historical original name of the association which goes back to the days of the Kingdom of Hawaii.

*Article 6, paragraph 4.* It should be made clear that the Council may not expel the President, Vice-President, etc., but that this may only be done by the House of Delegates. This may be accomplished by adding the sentence "This function may never be exercised by the Council," after sentence 3, paragraph 4, article 6.

### B. SUGGESTED CHANGES IN BY-LAWS

#### CHAPTER I. COMPONENT SOCIETIES

*Chapter 1, section 8, sentence 1* of the By-Laws reads "Each component society shall be entitled to send to the House of Delegates one delegate or his alternate for every 25 members, etc."

*Sentence 2.* "At a meeting prior to the annual meeting each society shall elect such delegates and alternates."

It has been proposed that the words "who are members of the A.M.A." be added to sentence 1, and that the sentence "such delegates and alternates shall be members of the A.M.A. with dues paid for the calendar year in which they are elected" be added at the end of section 8.

Shall active participation in the government of our association be limited to members of the A.M.A.? If so, the position of those members of the association not members of the A.M.A. becomes reminiscent of our situation as American Citizens residing in Hawaii—taxed, but unable to vote. Your chairman vigorously opposes this proposed amendment, but offers it to you for your consideration.

If this amendment be adopted, your chairman recommends that the position of the association be made completely clear and unequivocal by adding to Chapter II, Section 1, MEMBERSHIP, the sentence "Membership in this association shall be limited to active, dues-paying members of the American Medical Association." Let us have no first and second class members.

#### CHAPTER III. OFFICERS

Clarification of the status and amplification of the duties of the President-Elect seems necessary. An active participation in the sessions of the House of Delegates and the Council would give the President-Elect a proper background of experience before he assumes his year of office as President. To accomplish this, a number of changes in the By-Laws are needed as follows:

*Section 2, paragraph A, sentence 4.* "The President-Elect shall be ex-officio a Vice-President, and shall act as President in the absence of the President during the



President's active term of office." It is recommended that the words "and a voting member of the House of Delegates and the Council" be inserted after the phrase "ex-officio a Vice-President."

*Section 3. Functions.* It is recommended that a new paragraph specifically outlining the functions of the President-Elect be inserted between the present paragraph A.—The President, and paragraph B.—Vice-Presidents. The present paragraph B. would then be designated paragraph C., etc.

The new section 3, paragraph B. would read as follows: "The President-Elect shall be ex-officio a Vice-President, and shall act as President in the absence of the President during the President's term of office. He shall be a voting member of the House of Delegates and the Council."

In the present section 3, paragraph B., the words "except the President-Elect" should be deleted.

*Section 4.* The words "the President-Elect" should be inserted after the word "President."

*Chapter 4, section 1, paragraph 3.* The words "other than" be replaced by the word "and".

*Chapter 5, section 1.* The words "the President-Elect" should be inserted after the word "President".

*Section 2, paragraph B.* It is suggested that the words "the secretary and treasurer shall be elected triennially" be changed to read "shall be elected annually."

The past two incumbents in these offices have requested the change, as they feel a three-year term has proven an undue hardship.

#### CHAPTER V. THE COUNCIL

*Section 2, paragraph E.* "No councillor shall serve for more than two consecutive terms or a maximum of three terms." It is recommended that this paragraph be deleted, since it is essentially undemocratic. The majority of the Society should be able to elect anyone they feel competent to fill this office without regard to terms of office.

#### CHAPTER VI. MEETINGS

*Section 3, paragraph A.* "There shall be an interim session of the House of Delegates to be called by the President approximately six months after the annual meeting."

Your present President has suggested that this be made more flexible by changing it to read, "There shall be interim sessions of the House of Delegates if and when circumstances make such a session necessary. Such sessions will be called either by the President on his own initiative or when he receives written requests for such a meeting from three or more members of the House of Delegates."

#### CHAPTER VII. ELECTION OF OFFICERS

*Section 3.* "Any person known to have solicited votes, etc."

It is recommended that this paragraph be deleted, as piddling, undignified, and unworthy of a place in a serious document.

#### CHAPTER XI. MISCELLANEOUS

*Section 1.* The phrase "No member shall speak longer than five minutes, nor more than once on any subject, except by unanimous consent."

Your chairman feels that elimination of rebuttal is not good democratic procedure. It is recommended that the phrase be changed to read, "Nor more than twice on any subject, except by unanimous consent."

### REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF CRIPPLED CHILDREN

**J. Warren White, M.D., Chairman**

The 1952 annual meeting was held in the Stella Lowrey Room of the Mabel Smyth Building. The following attended:

Dr. J. Warren White, *Chairman*  
Dr. Wayne Wong  
Dr. Ivar Larsen  
Dr. William Holmes  
Dr. L. Q. Pang  
Dr. D. Uyeno  
Dr. W. J. Seymour  
Dr. E. A. Tompkins  
Dr. Jay Kuhns

Dr. John Reppun  
Dr. W. Wilkinson  
Dr. K. J. Edgar  
Dr. C. L. Wilbar  
Dr. W. B. Quisenberry  
Dr. P. Kim  
Dr. T. G. Lathrop  
Dr. F. J. Pinkerton  
Dr. N. Steuermann

The recommendations of the committee are as follows:

1. Recommended that referral for clarification of the appointment of the Crippled Children Advisory Committee in an advisory capacity to the implementation committee for Act 29 be referred back to the House of Delegates with the suggestion that a joint committee of members of Maternal and Child Health and Crippled Children Advisory Committees might serve more effectively.
2. Requested that Bureau of Crippled Children clarify to the Medical Society and other interested agencies its stand on treatment and care of eye conditions in relation to fund insufficiency.
3. Recommend that efforts for raising the Bureau of Crippled Children allotment by the next legislature be continued and that a definite attempt be made to determine when hearings are held and that members of this committee work closely with the Health Department personnel in interpreting to legislators the need for an increased allotment.
4. Recommended that a memorandum relating to the law requiring registration of children having crippling conditions that occur subsequent to birth be sent to physicians in the Territory including a list of conditions to be reported.
5. That a statement of notification of the 3-month waiting period on acute traumatic conditions be sent to physicians so that arrangements for other care can be expedited.
6. Recommended that children having conditions causing bilateral blindness be registered with the Bureau of Crippled Children.
7. Recommended that Bureau of Crippled Children prepare and circulate to committee members an annual report of cases cared for and monies expended in advance of the next annual meeting.

### REPORT OF THE ADVISORY COMMITTEE ON CHRONIC ILLNESS

**Shoyei Yamauchi, M.D., Chairman**

Chronic disease has emerged in the past thirty odd years as the greatest medical problem facing the practicing physician, his allied workers in the health field, his patients and the citizens of the community in which he lives. However, the pictures of hopelessness and helplessness which were invariably associated with chronic disease have taken on a *new* meaning and there is an air of optimism, hopefulness and cheerfulness at the national and territorial levels. This changing atti-

tude is attributable chiefly to the emergence and developments of three factors.

1. The organization of the National Commission on Chronic Illness in 1949.
2. The accomplishments, that medicine and its allied sciences have already made in the prevention and control of certain long-term diseases, and, finally,
3. The realization that we are, today, on the threshold of the golden age of achievement in their prevention and control.

A *unified, single-front* attack on chronic disease was heralded by the formation of the National Commission on Chronic Illness in May of 1949. This *independent* organization was founded jointly by the American Medical Association, the American Hospital Association, the American Public Health Association and the American Public Welfare Association.

*Developments* in the field have been *rapid*. The U.S. Public Health Service has created (1949) a division of Chronic Illness, which has carried out extensive experimentation in several mainland cities. The American Association of Nursing Homes, which was organized in September of 1949 by representatives of 16 states is active in the standardization of nursing homes.

The immediate need for planning at state, territorial or local community level was emphasized, when, in May 1949, health officers from California, New York, Connecticut, Florida, Massachusetts, Michigan, Mississippi, Montana, Oklahoma and Wisconsin, in response to a questionnaire sent out by the Commission to all states, reported that the control of chronic illness was their major concern. Many states are already well-launched on very comprehensive programs to conquer this problem.

Our Advisory Committee on Chronic Illness, which was created last May, entered the exploratory phase of its activity with enthusiasm and vigor. "To define the problem"—this appeared to be the task of the highest priority in the list of jobs to be done and in the phasing schedule for accomplishing these jobs. To do this, the committee felt that a community *survey* to determine the extent and nature of our problems and needs was necessary. With this in mind, the committee appointed various project chairmen, who have already begun their work.

We have defined chronic illness to mean: Any disease which by its persistence or recurrence is capable of causing prolonged incapacity.

In the past half a century, some of the previously important acute infectious diseases were eliminated, but, now, we are beginning to harvest a "bumper" crop of these "chronic" diseases which increase in incidence as individuals grow older.

This is not to say that chronic disease does not affect the young or the relatively young also. It is estimated that over 50% of people with chronic disease in the nation are under the age of 45, and 16% are under the age of 25 years.

We know that chronic disease affects about 8 million people in the United States; it accounts for 3 out of 4 hospital beds in the nation, causes two-thirds of all deaths and 60% of all disability; and perhaps, most unfortunately at a time of great need for national productivity, chronic illness accounts for the loss of over one billion productive days every year.

While the problem nationally and locally in the Territory is similar, it is impossible to superimpose chronic illness problems existing in Dallas, Boston, or Seattle upon our own. Ethnic variations in Hawaii is one example of the unique regional difference between us and the mainland United States. Another difference is that the average age of our population in Hawaii is comparable to what it was in the mainland United States fifty years ago.

By surveying our community to find the exact nature and extent of our own chronic illness problem, we will be able to determine the final structure and form of program which will be needed here.

Whatever the specific activities we are to follow for the control of chronic diseases in Hawaii, there is a fundamental approach which has been agreed upon by the National Commission on Chronic Illness and by workers in this field throughout the country.

This approach has been called the "common-denominator" approach. It implies, simply, that there are several basic areas of activities, which will produce the best results in controlling long-term diseases. These common denominators are:

Prevention—Early detection, early diagnosis,  
early treatment.  
Hospital Care  
Convalescent and Nursing Home Care  
Domiciliary or Home Care, and  
Rehabilitation

In some of these areas, our community will have to start practically from scratch. In other categories, such as that of rehabilitation some ground work has already been done.

The solution of the problem, then, will require: First, a survey, to determine the exact nature and extent of the chronic illness problem in the Territory; second, the use of the "common-denominator" approach in organizing the structure of the program; and, third, working out the specifics of action in each of these categories.

The bond which will hold together all of our resources must necessarily be cooperative action and teamwork. Concerted efforts among the Territorial Medical Association, Territorial Department of Health, Territorial Department of Public Welfare, and the hospitals of the Territory will be imperative.

## Recommendations

Our committee therefore recommends:

1. That the Territorial Medical Association request the Governor to form a Commission on Chronic Illness, and
2. That the Territorial Medical Association strengthen the present Advisory Committee by setting up a "Committee on Chronic Illness" for each County Medical Society with a representative on the Territorial Advisory Committee.

The re-enforcing of the existing Advisory Committee is urgently needed and the creation of a Governor's Commission is an absolute necessity since all aspects of our community life must be represented if we are to be successful in the prevention and control of chronic diseases, and in the rehabilitation of those unfortunates who suffer from them.



# REPORT OF THE ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL AND CHILD HEALTH AND OF THE SUBCOMMITTEE ON MATERNAL, FETAL & NEONATAL MORTALITY

**Duke Cho Choy, M.D., Chairman**

The committee held five meetings during the year.

Eight maternal deaths with the following diagnosis were studied:

- 4 eclampsia or toxemia
- 2 hemorrhage
- 1 cardiac decompensation
- 1 hyperemesis gravidarum

Suggestions and recommendations made by the committee were made known to the physicians handling the cases whenever requested.

Infant deaths resulting from prematurity, tetanus, diarrhea of the newborn and congenital hemolytic disease were discussed. Diagnostic and treatment problems were reviewed. Suggestions for treatment and management were outlined. The following efforts were made to notify the association members of these recommendations:

1. Blood Bank personnel participated in the Rh factor discussion and prepared suggestions for management of the maternity patient with rising titers and for management of the newborn with evidence of erythroblastosis.
2. The discussion of prematurity led by Dr. L. Phillips with a review of the statistics of the infant premature deaths at Kapiolani Hospital was followed by the preparation of an article for the HAWAII MEDICAL JOURNAL on the suggestions for management of premature labor and care of the newborn premature.
3. The study of epidemic diarrhea in a newborn nursery was followed by an editorial in the JOURNAL on suggestions for control and prevention of that condition.

The mortality study forms for maternal and infant deaths have been simplified and new forms are now in use.

The procedure for presenting case studies of maternal and infant deaths was revised after consultation with mainland committee doing similar work.

The committee assisted the Bureau of Health Statistics with the interpretation of the new legislation requiring that all abortions be registered as fetal deaths.

Questionnaires from three states regarding our committee work were answered.

The legality of the use of hospital records for studying of maternal and infant deaths was clarified through the Attorney General's Office.

In the annual meeting, May 1, 1952, recommendations on the following subjects were made:

1. The use of fibrinogen in states of defects of blood coagulation.
2. Child health conference policies relating to immunization and patient referral.
3. Implementation of education for parenthood in the high schools.

Final action on these subjects will be reported at the next annual meeting.

## Present membership:

Oahu:  
Dr. Duke Cho Choy, *Chairman*  
Dr. S. Nishijima  
Dr. L. T. Chun  
Dr. C. A. Wyatt  
Dr. F. C. Spencer  
Dr. H. M. Patterson  
Dr. George M. Ewing  
Dr. W. B. Herter  
Dr. K. S. Tom  
Dr. William Walsh  
Dr. John G. Lynn IV  
Maui: Dr. E. A. Tompkins  
Hawaii: Dr. W. J. Seymour  
Kauai: Dr. J. M. Kuhns  
Lanai: Dr. W. Wilkinson  
Molokai: Dr. J. I. F. Reppun  
Health Department:  
Dr. H. E. Bowles  
Dr. K. J. Edgar  
Dr. K. Takenaka

## REPORT OF THE CANCER COMMITTEE

**G. A. Batten, M.D., Chairman**

The slogan, "Every doctor's office a cancer detection center" is becoming more and more a reality as our doctors continue to take advantage of the advances being made in cancer diagnosis.

As in the past, the Territorial Medical Association has cooperated very closely with the Hawaii Cancer Society and other agencies interested in various phases of cancer control.

The joint efforts of these organizations are described under the following categories:

**Professional Education:** All physicians in the territory—and all dentists since last September—have received The Cancer Bulletin monthly by courtesy of the Hawaii Cancer Society.

That society's professional education committee has arranged to bring Dr. William A. Boyd, Professor of Pathology at the University of British Columbia, to Hawaii. He will be one of the main speakers for the annual meeting of our association and will give nine other lectures in Honolulu and at least one on each of the other islands.

**Medical Services:** The cytology laboratory at the offices of the Hawaii Cancer Society in Honolulu continued to function throughout the year. The Kauai Cancer Society sent a laboratory technician to the University of California for training in cytology and upon her return last fall she set up a laboratory at the Samuel Mahelona Memorial Hospital. Suspicious slides from both laboratories are reviewed by the Committee of Medical Cytologists in Honolulu. The Maui chapter has sent a technician to the mainland for similar training and will sponsor a laboratory on its island upon her return. Two hundred and twenty doctors have sent 13,000 slides on 8,000 patients to the Honolulu laboratory since it was established in July, 1949. Of these, 52 vaginal smears proved positive and 59 suspicious, and 18 smears other than vaginal were positive and 23 suspicious.

Very successful tumor clinics have been conducted at Queen's, St. Francis and Kuakini hospitals. The tumor clinics have been valuable not only in advising physicians in the diagnosis and treatment of cancer but as an excellent educational medium as well.

**Research:** Very careful consideration is being given to the possibility of advancing the use of the cytologic technique in detecting cancer in parts of the body other than the vaginal tract. The papain test which was developed at the University of California is being studied as a means of diagnosing cancer of the stomach.

Statistical studies are being conducted by the Cancer Society and the Department of Health to determine the racial differences in incidence of cancer of various parts of the body. The morbidity study financed by federal funds has continued under the Department of Health, with the Cancer Society and the Territorial Medical Association assisting in an advisory capacity.

**Public Education:** The film "Breast Self-Examination," which was prepared by the American Cancer Society and the National Cancer Institute, has been shown throughout the Territory. At a very large percentage of the showings, a physician has been present to answer questions and lead the discussion. A special effort has been made to bring the cancer control program to the previously unreached women in business and industry.

It has been suggested that (1) a committee be appointed under the joint auspices of the Hawaii Cancer Society, Territorial Medical Association and the Department of Health to investigate research possibilities in Hawaii in the field of cancer; (2) consideration be given to the possibilities of bringing to Hawaii an outstanding authority in the field of epidemiologic research.

Your representatives on the executive committee of the Hawaii Cancer Society thought this was of such importance that they should discuss the subject with the Cancer Committee of the Territorial Medical Association before committing themselves on the subject.

Because of the advisability of having the maximum number of committee members possible present from the islands other than Hawaii, a meeting has been called to take place at the time of the annual meeting.

1 1 1

The following recommendations were made:

1. That a committee as suggested in a communication sent by Mr. Rhea, signed on April 29, 1952, be appointed to explore the research possibilities in connection with cancer in Hawaii. In as much as the members of the Medical Society have positive views as to what should and should not be done in this connection, it was requested that this committee report its findings and recommendations to the Cancer Committee of the Hawaii Territorial Medical Association before deciding on any definite research undertaking.

2. The committee thought it inadvisable to bring a mainland physician to Hawaii in connection with cancer studies.

3. The committee was divided in opinion as to the advisability of making cancer a reportable disease. It was suggested that letters be sent to Dr. Pack and to the American Cancer Society inquiring what actual benefit has been derived by making cancer a reportable disease in the State of New York.

The advisability of making radio isotopes available in Hawaii was discussed. It was brought out in the discussion that The Queen's Hospital is definitely committed to including in its building program a physical plant adequate for the use of isotopes. The committee

felt that such facilities should be made available to the citizens of Hawaii without unreasonable delay. It was felt that due to the limited application of this form of therapy one such set up would adequately serve the Territory's present needs.

**NOTE:** This meeting was held at the same time as the Delegates' Annual Meeting in order that the doctors from neighbor islands might attend. Therefore the above recommendations were not ready in time to be included in the annual report presented to the delegates.

## REPORT OF THE EMERGENCY MEDICAL SERVICE COMMITTEE

Robert B. Faus, M.D., Chairman

The attached report reveals the names of physicians called and about to be called to active duty with the military. Dr. Dawe has handled all correspondence relative to dentists. No deferments were asked or granted for dentists.

All deferment requests for resident physicians were granted for 6 months. Additional deferments were granted on request of Hospital and Physician for second 6 month period. No deferments were allowed beyond the second request. All Priority I and II physicians will be subject to call after July 1, 1952.

In conclusion your committee recommends

That the EMS committee remain a part of each County Society organization;

That Honolulu County Society EMS committee plus the outside island chairmen constitute the Territorial EMS committee;

That interest in Civil Defense be maintained at a high level;

That all physicians lend wholehearted support to training programs.

Present status of Hawaii doctors (March 20, 1952):

### Active Service:

Capt. Edwin B. Adams  
Capt. K. S. Chang  
Capt. Yasuyuki Fukushima  
1st Lt. Marion L. Hanlon  
1st Lt. Richard W. Neil  
Capt. William B. Simpson  
Also 1st Lt. Richard Y. T. Wong (registered with mainland Selective Service)  
Also Major R. P. Wiperman who volunteered for service in Korea

### Army Reserve—subject to call April, 1952

1st Lt. Edwin R. Ballard, Jr.  
Capt. Kikuo Kuramoto  
Capt. Shigeo Shinkawa

### Classified 1-A-M

Pritchard Lam  
Sydney Fujita

### Deferments

Warren Wong—June 30, 1952  
Richard K. C. Chang—July 1, 1952  
Wallace E. Chin—July 1, 1952  
Richard Lam—July 1, 1952  
Walter S. Strobe—August 12, 1952  
Sheldon Cholst—August 19, 1952  
Herbert Pang—October 1, 1952  
James G. Harrison, Jr.—November 20, 1952

### To be called in July, 1952

Keith Kuhlman  
Samuel C. Y. Lui  
Chew Mung Lum  
Roy R. Ohtani





# ANYWHERE

## ...by air

Wherever you're going . . .  
anywhere in the world, on  
*any* airline, let Davies' air travel  
experts smooth out your pre-travel  
worries. At no extra charge,  
DAVIES:

- Helps plan your trip
- Makes your reservations
- Gets your tickets . . . and  
delivers them to you!

Authorized agents for  
airlines all over the world,  
and for hotels and connecting  
transportation, Davies can make  
your air travel *anywhere* your  
own magic carpet.

*Air Division, Travel Department*

# THEO. H. DAVIES & CO.

Bishop and Merchant Sts., Phone 5-6991

*A phone call brings our representative.*

# INTER-ISLAND NURSES' BULLETIN

*Official Publication of the Nurses' Association, Territory of Hawaii*

---

LEONA R. ADAM, *Executive Secretary*, Honolulu

## BULLETIN COMMITTEE

CLAIRE CANFIELD, *Editor*, Board of Health, Honolulu

LORETTA SCHULER, *Nursing Information Committee*, ARC, Honolulu

JUNE APO, Honolulu

ALICE SCOTT, Honolulu

MARJORIE ELLIOTT, Honolulu

MARGARET BARNETT, Hawaii, *Secretary*

JOANN GROBERG, Maui, *Secretary*

MYRNA CAMPBELL, Kauai, *Secretary*

GLADYS LEONG, Oahu, *Secretary*

---

## PRESIDENT'S MESSAGE

We are living in one of the greatest periods in the history of Nursing. Our six delegates who are representing us at the Biennial carry with them this challenge.

As we look forward to our Twenty-First Territorial Conference in October, it is your duty and mine to be prepared through study of the New Structure and By-Laws to take the necessary action to promote our own N.A.T.H.

We who live in America have the opportunities and obligations that go with Freedom and Liberty. It is our duty and privilege to attend these meetings and plan the course of our Association.

ARLENE N. THOMPSON, R.N.

## BROADER HORIZONS IN MATERNITY NURSING SERVICES

LEONA RUBBELKE\*

Her baby had been born ten days earlier. She was sobbing in the garden where her mother had directed me. "I don't know what ails her, she won't eat right and certainly will lose her milk for the baby." We were friends from those mother class days and she greeted me now. "I am glad you came. Don't know why I can't seem to snap out of this. I know it is foolish, too."

"Not really foolish—rather natural. You know you got up very soon and now, after being home a while, things sort of pile up on you." She smiled and we chatted a while. Then with a rush of con-

fidence—"I've wanted to tell someone so badly—I've been ashamed and upset ever since. You know when the pains came I was in the garden barefoot, and they seemed so hard I just forgot everything and ran to the field for John, and we did just barely get there. When they put me under I heard the nurse say, 'Careful there, her feet are a mess.' I was so ashamed I just can't get over it. I couldn't even tell John. He wouldn't understand."

Just a careless word, not malicious, not mean, just thoughtless, and the hours of shame, resentment, and pain that followed.

Sometimes the woman in labor is looked upon as a swollen, pulsating uterus, anxious to disgorge its contents—with our primary interest in seeing that the process moves along as rapidly and smoothly as possible. Anxiety is centered around the doctor getting there "just in time"—not too late and, certainly, "not too soon." It sometimes seems the nurse's primary responsibility is to have the doctor come as late as possible—but her greatest error is to let him miss a baby. Thus, in trying to create good obstetrical nurses we developed experts at diagnosing the stage of labor and the station of the child.

Maternity nursing is concerned with parent education, good nursing care and prevention of maternal and infant deaths. Professional nurses today are far more concerned with the total woman than they used to be; even more, they are interested in the family—anxious to make the delivery and addition of a new baby a happy, satisfying experience for the family and an interesting and shared experience for father and mother. With

\* Maternal & Child Health Nursing Consultant.



a growing awareness in the world today of the importance of "family living and family life," we add to our professional duties the job of helping parents take an eager, rewarding part in the process that is as old as time and as new as dawn. We no longer say, "The doctor delivers the baby," but rather "You are getting ready to deliver your baby. Soon the doctor will come to help you." A team of father, mother, nurse, and doctor work together to safely usher a new life into the world. The good obstetrical nurse judges the progress of labor as far as possible by outward signs and patient's responsiveness, fetal heart tones, and character of contractions. Rectal examinations are only to verify what she already suspects. Recently a patient in mothers' class recalled having 19 rectals in 3 to 4 hours of labor as the most painful thing about having her baby. Even allowing for the well known "stretch of imagination" this brings home the need of real discretion in the use of such a diagnostic aid. Great physical and emotional discomfort and a measure of real danger accompany too frequent rectal exams on the patient in labor.

Nurses can make real contribution in parent education. Office nurses teach the father and mother from the first prenatal visit—reassure them, answer their questions. Public health nurses in homes, clinics and parent classes share with the doctors the important job of developing understanding and informed parents; when to call a doctor, what to watch for in mother and baby, how to avoid trouble and how to meet it when it comes. Parents should know a *baby* is everyone's interest as well as theirs. The child is the parents' primary responsibility and privilege, but if special problems come up, and if the burden becomes too heavy, there are community resources they can fall back on or call for help. These reassuring facts can be made known to parents by well informed nurses. Physicians generally value the complementary and cooperative efforts of the nurses. They tend to make the demands of parenthood less threatening, and more rewarding to the young couple. In this way the *nurse* is often able to help promote the integrity of family-physician relationship. As she teaches about resources, she emphasizes that these are available through the family physician.

Parent classes are found in almost every up-to-date community. Here in Hawaii, they are taught through a cooperative plan of the American Red Cross Nursing Service and the Bureau of Public Health Nursing. Some physicians are arranging regular parent education classes for their own patients. Mothers' classes are also offered at all

out-patient departments in Honolulu hospitals. Night classes are available at adult education projects for both parents. Hospital nurses augment these efforts with their demonstrations of baby baths, formula making, breast feeding, etc.

Natural childbirth or delivery of the baby with a minimum of sedation and maximum awareness and interest on the part of parents is receiving much popular attention by the general public. The following features of the method which require emotional and mental well-being as essential to a satisfactory pregnancy and delivery have received wide approval by obstetricians. The major advantages they stress are:

1. The sensible exercises recommended strengthen muscles used in child bearing and help to keep the pelvic joints and hinges supple.
2. Maximum relaxation reduces the amount of discomfort for the mother, shortens the labor, and minimizes general fatigue.
3. Psychologically, the active participation of the mother seems to give her great satisfaction and does allow her to be alert and awake to see her infant as soon as it is born.
4. Permitting father and mother to share the early labor period and both take part in educational discussions whenever possible increases the self sufficiency and adequacy of the family for delivery and baby care.
5. The smaller amount of analgesia and anesthesia required adds a safety factor for mother and baby and eliminates some of the fear the mother has of dying or of losing consciousness.

In addition there are advantages for the nurse and physician working on a service offering rooming in and natural childbirth for they share the excitement of helping young parents enjoy this rich experience. It creates an ideal situation for sharing knowledge with both parents, in a warmly permissive atmosphere at a time when both parents are eagerly receptive; it is indeed gratifying to send home an adequately prepared and happy family unit. These are rewards!

With respect to the fathers' role in maternity work we have travelled far afield. From being chief anesthetist, assistant obstetrician and tender of the newborn in home deliveries, their position has been relegated to an undignified post of paying bills and bringing in and taking home the mother and child. Not infrequently they are advised to "run along home—we will call you when we want you." Recently a planning group reviewing hospital plans decided they did not need a father's waiting room as they were a nuisance around and better off on another floor or home. It certainly does not foster family solidarity to separate father and mother in early labor and not allow them to see each other until after the baby is born.

Fathers have almost as many fears and apprehensions about the mystery of childbirth as mothers. To be relegated to walk and wait and worry while the wife is upstairs, lonely and afraid and wondering about her husband, is destructive. As obstetrics focussed more and more attention on aseptic technics and carefully considered procedures, the warm human aspects of the art were more or less lost. When fathers are well prepared and well informed they make excellent back rubbers and good companions. A little patience, showing how, explaining what is happening, and they can offer emotional comfort and support. This is good for the father too and gives him feelings of adequacy and helpfulness. Visiting, playing cards or doing puzzles, reading, listening to the radio are all harmless time passers. There is less worry and anxiety, less demand for analgesia, the mother relaxes better, and the time goes faster if the patient is kept occupied.

At no time is nutrition so important as in pregnancy—for the mother and for the child. This is potentially a good time to promote improved family food habits. The nurse who visits with or cares for maternity patients needs a well rounded knowledge of basic principles of nutrition, especially for the antepartum, postpartum and lactation period. In Hawaii, we need more—a broad knowledge of local foods, racial dietary patterns and the ability to offer practical suggestions that will be acceptable to the many interesting groups we serve.

We are particularly aware of the importance of good nutrition in premature labors. So frequently the patient is admitted, just following a hospital meal. Food is served at varying hours in homes and she may not have eaten for 5 or 6 hours. By the next regular meal she has progressed too far for a satisfying meal so may come to the hardest part of childbirth with an aching, empty stomach, a low blood sugar, and exaggerated fatigue. Labor and "birthing" a baby with or without anesthesia is the hardest job a woman can do. Nutritionally prepared for it she will be more stable emotionally, more adequate physically and better able to cooperate. What she may eat must of course be decided by the physician, but the nurse should always know when she last ate, what she can have and must see that she gets nourishment regularly. Adequate meals are often permitted in early labor—fruit juices, liquids, ices or broths, as progress allows.

Admission histories take on new significance. Besides an interest in recent food intake and the usual identifying and medical data, the family's recent health in relation to diarrhea, rash, flu is of

interest. In the patient herself a special note should be made of any boils, infected hangnails, G.I. upsets or loose stools. Adequate attention to such details will help reduce frequency of diarrhea in newborn nurseries, infected sore nipples, colds, influenza, etc. on maternity wards.

Nurses play an important role in helping to reduce maternal deaths of which the leading causes in Hawaii and throughout the world are toxemia, hemorrhages, septicemia, and anesthesia.

*Toxemia:* Office nurses, public health nurses, industrial nurses and hospital nurses all have a chance to teach patients. They can emphasize the importance of early and continuous medical supervision. They can be alert for untoward symptoms. Actually an opportunity to talk with and to listen to potential parents is one of our greatest privileges. To do this constructively takes time—interest and the ability to be keenly observant. Good nutrition which is a factor in avoiding toxemia is most effective when promoted in the first trimester. It is more successfully established if office nurses, public health nurses, and physicians work hand in hand. Problems related to toxemia are met with less difficulty if discovered early. Informed prospective parents and alert professional people who come in contact with the expectant mother are paramount in avoiding deaths from eclampsia.

*Puerperal infection:* Still is a killer. We have antibiotics, sulfa, blood and blood plasma—but mothers still die from infection.

One mother delivered her baby in the yard trying to get to the car. They did not know that an intact cord is a protection, that it was harmless to let the cord alone until they could reach the hospital.

Another mother had a rush of water two weeks before her baby was due. No pains, so she waited until she felt badly two days later to go to the hospital.

Persistent education of all the people can help prevent such tragedies.

*Hemorrhage:* "Just three pads, nurse—nothing to worry about. It even stopped when I went to bed. It did start as soon as I got up but the kids came home from school. I couldn't let them know. You understand."

And the 16 year old unmarried mother who was nearly exsanguinated when the doctor reached her. The baby wasn't due for 4 months, she hadn't sought medical care nor had she found it possible to talk to her parents about her problem. Maternal mortality is far more common in the 15 to 19 year olds than in other age groups. These young mothers should be sought out and offered what-



ever help and comfort is available. They are frequently fearful, facing grave social and economical problems and in need of understanding help.

*Anesthesia:* In trying to make women's lot easier we must nevertheless avoid taking chances with life. Nurses can do much to help mothers minimize the discomfort of labor and face delivery with a wholesome, less fearful attitude. The mother cooperates best when she knows that early labor is only opening the uterus and that the process will move along more smoothly if she can achieve maximum relaxation. Breathing deeply with the abdominal wall pushed away from the laboring uterus she can help direct the baby through the birth canal in a straight path. A tight abdominal wall and tense uterus result in a contorted route because the baby's head is forced against the pressure of a resisting cervix and pelvic rim.

Too often, our very human concern to relieve pain keeps us from encouraging the mother to participate as fully as she might and hence derive the real satisfaction that comes from the achievement of taking an active part in the birth process. Mothers in labor should not be left alone but obstetrical units are too busy to provide constant attendants. Perhaps then some member of the family could be permitted with the woman in early labor as long as possible. Why not the father?

Though limited by shortage of personnel and inadequate facilities, nursing is making constant progress and providing the most skillful service possible under existing conditions. Practicing the human arts of listening, understanding, and teaching will enrich total nursing tremendously. With increased interest in the family and keen observation for the unspoken needs of both parents, much can be done to make childbirth a less fearful and happier experience for many families.

#### References—Resources

- Anxiety in pregnancy and Child birth.* Klein, Potter, Dyk, 1950. Harper Brothers.  
*Obstetrics.* Eastman.  
*Natural Childbirth.* G. D. Read.  
*Nursing of Children.* 6th Ed. 1948. Sellen, Walters, Harvey.  
*Textbook of Obstetrics and Obstetric Nursing.* 3rd Ed. 1949. Book-miller and Brown.  
*The Rights of Infants.* 1943. Margaret Ribble, M.D. Columbia Press.

### PREPARING NURSES TO TEACH CLASSES FOR PROSPECTIVE PARENTS

ALISON MacBRIDE\*

Teaching classes of expectant parents is an established part of the public health nursing program. Parents usually hear about the classes from their physician or through newspaper publicity. The Hawaii Chapter of the American Red Cross

authorizes our nurses as teachers, provides equipment as needed for classes and issues a certificate to the parent upon completion of the course.

Both in Hawaii and on the mainland, group instruction is popular with parents and has been found to be an effective supplement to the individual guidance given in the physician's office or the antepartal clinic. Parents are helped toward a better understanding of experiences with hospital and medical service. Many of the fears commonly associated with childbearing can be allayed in the group situation. This is especially true of fears deriving from the unknown and unfamiliar and the misconceptions seeded by "old wives' tales." Anxieties are reduced when normal physiological processes are understood and the events common to childbearing can be anticipated. Self confidence is nurtured in the expectant mother as she steps into her future role in the practice periods devoted to formula making, dressing and bathing the infant.

To prepare a core of nurses for this teaching program, an institute was held last fall by the Bureau of Public Health Nursing. The institute teaching staff (nutritionist, maternal nursing consultant, American Red Cross, field supervisor, health educator, mental health nursing consultant, and nurses with experience in group methods) met with those coming to the institute to plan the program.

In this planning conference it was decided that the institute should provide a review of modern trends in obstetric care and of the scientific knowledge available on the normal maternity cycle; that it should develop understanding of group process and methods; that the instructors should become familiar with audio-visual materials and their use with parents' classes; that the educational principles applicable to classes where demonstrations are given should be reviewed; and that there should be discussion on the problem of integrating nutrition and mental hygiene concepts in the teaching program. With the formulation of these specific goals for the institute a program was defined.

As the institute progressed, a council representing the nurses and the teaching staff met regularly to modify the program in terms of the criticisms and suggestions which came in from the "post-meeting reaction" forms. The council found that more time for discussion was needed; that the group was calling for consensus opinions on certain teaching policy questions; and that there were special areas of teaching which had not been included. In short, this council provided for further adaptation to the needs of the group which evolved during the institute.

\* Educational Director, Bureau of Public Health Nursing, Territorial Department of Health.

Role playing was used in some of the sessions on methods. The opening class with parents and the discussion session following the giving of information on fetal development were reproduced by role playing. This brought into realistic focus several problems the instructor usually has to meet in the class situation.

The final session attempted to evaluate the institute program by means of rating the adequacy with which the specific goals for the institute had been met. From these opinions the group concluded that the institute had been a satisfying educational experience, on the whole, with the exception that group process and cultural differences should have been focussed to a greater extent in the program. The "real proof of the pudding" will be tested by each nurse in her teaching experience with parents' classes this year.

#### POLIOMYELITIS NURSING INSTITUTE 1952

Nursing Institutes on Poliomyelitis have been presented on Maui, Hawaii and Oahu, in February, May and June, respectively. The Nurses' organizations have taken an active part in planning and presenting these programs with the cooperation of the local chapters of the National Foundation for Infantile Paralysis and the American Red Cross Nursing Service with the assistance of local physicians. The American Red Cross Nursing Service, under Loretta Schuler, has been particularly instrumental in meeting the needs of local hospitals for poliomyelitis nursing care, and has promoted interest among nurses to seek the benefits of these programs.

These Institutes have been conducted for three separate sessions totalling an average of eight hours each. Practical nurses, office nurses, public health nurses, institutional, industrial, as well as retired nurses, and physical therapists have been well represented at these meetings. The attendance on Maui totalled 80; Hawaii 60; and Oahu 250.

The ultimate aim of these programs is to prepare more nurses for poliomyelitis nursing, in order to meet the needs of these patients in the hospitals and in the community. The responsibilities of the nurse were strongly emphasized through the lectures on the medical aspects of the disease during the early, as well as in the convalescent stages. The NFIP films on nursing care have been effectively used to illustrate nursing skills in detail, along with a more recent one on "Diagnosis of Poliomyelitis." Demonstrations of hot packs and the respirator were presented by nurses who were especially trained in poliomyelitis nursing. The nurse participants in these institutes

were Miss Veronica McDermott, Miss Hannah Richards, Mrs. Frances Nakatsuka, Miss Audrey Booth and Miss Mildred Asato. Mrs. Sybil Voorheis and Miss Paula Sorg, physical therapists, presented their role in the overall care of poliomyelitis patients.

Dr. Quisenberry, Chief of the Division of Preventive Medicine, Department of Health, spoke on the "Community Aspects of Poliomyelitis," and reported that 54 per cent of the victims in Hawaii were children under five years of age. In the first five months of this year there were 32 cases, as compared to 16 in the whole year of 1951; 31 in 1950; and 20 cases in 1949. He named the community agencies which should function cooperatively in case of an epidemic, such as the National Foundation of Infantile Paralysis, American Red Cross Nursing Service, Bureau of Crippled Children and other bureaus of the Department of Health, schools, hospitals and the medical and nursing professions.

Lt. Col. Walton Edwards, Chief of Pediatrics at Tripler Hospital, pointed out the difficulties encountered in diagnosing early poliomyelitis, by citing the numerous different diseases which may simulate poliomyelitis in its early stage. "There is still no specific drug, or antibiotic against this disease," he said. "Poliomyelitis is still more of a nursing problem than a medical problem after it is diagnosed."

Dr. J. Warren White, Chief of the Shriner's Hospital, spoke on the management of convalescent poliomyelitis, and stressed the importance of working with the physical therapist in all stages of the disease, and particularly beginning the early convalescent period. "During this stage efforts should be directed towards the prevention of deformities which may develop. Some of the common deformities to be guarded against are equinus, flexed knees, scoliosis, flexed hips and abducted hips. These are to a large extent preventable through early recognition and correction of faulty bed positions, by the use of protective braces and footboards, and by the institution of physical therapy. Hot packs, muscle training and frequent manipulation of joints are carried out under the direction of the doctor, with the cooperation of the physical therapist. Surgical procedures such as tenotomies and osteotomies are resorted to for the correction of deformities. In the reconstruction program two of the more common operations are stabilization of joints, and transplantation of muscles."

The need for teamwork among all personnel concerned with the welfare of the patients with poliomyelitis is evident. Pediatrician, orthopedist,



neurosurgeon, physical therapist and nurses work closely with their patients, and cooperative planning is necessary to meet the total needs of these patients. As a result of these institutes it is hoped that instructors in nursing schools, head nurses and supervisors who have attended these meetings will assist with the planning and conducting a continuous in-service program of education and orientation in their own hospitals and affiliated agencies. Also, that hospitals and nurses' associations will be encouraged to utilize the available scholarships for the preparation of their nurses and physical therapists for specialized poliomyelitis care. Only through sustained interest and corresponding activities can we maintain an adequately prepared staff within our organizations which will be ready to render the best type of nursing care in this area.

We of the nursing Committee on Polio Institute wish to express our appreciation to all of the participants, and especially to Dr. Richard Lee, Dr. Ivar Larsen and Dr. Thomas Bennett.

MILDRED ASATO, R.N.

## INTERNATIONAL CONGRESS OF NURSES

Word has been received that the tenth quadrennial meeting of the International Congress of Nurses will be held in Rio de Janeiro in 1953. Sessions are scheduled to begin July 13 and will extend over a five day period. More specific details will be announced at a later date.

## OFFICIAL DELEGATES TO 1952 BIENNIAL

1. H. Eileen MacHenry, industrial nurse, pineapple company on Maui, presently attending Yale University, New Haven, Connecticut, from Providence, Rhode Island.
2. Dorothy Sakamoto, general duty at Queen's, attending University of Pittsburgh.
3. Clara Mitchell, Hawaii, office nurse for Dr. H. Crawford, Hilo, from Sacramento, California.
4. Mrs. Rosie Kim Chang, Educational Director, Queen's Hospital.
5. Mrs. Alice Scott, appointed but will not be able to attend.
6. Leona R. Adam, attending meeting of State Board of Nurse Examiners—June 10-13, also biennial meeting of ANA—June 14-20.

## ANNUAL CONVENTION

Mrs. Esther Stubblefield, President of the Nurses' Association, District of Oahu, formally announced the dates of the Annual Convention at the last regular monthly meeting of Oahu District June 2.

Preliminary information regarding these meetings to be held October 27, 28, and 29 gives promise of timely and stimulating sessions. The major theme will be "Human Relations in Nursing." Miss Ella Best, American Nurses Association, guest speaker at the convention, will discuss the new nursing structure and the economic security program for nurses.

Detailed program plans are presently in the process of completion, and will be available in the September-October issue of the INTER-ISLAND NURSES' BULLETIN.

## NOTICE—HAWAII LEAGUE OF NURSING EDUCATION

The Curriculum Committee of the Hawaii League of Nursing Education will make plans to conduct a refresher course for inactive graduate nurses again this year if the number of applications justifies it. Will all graduate nurses who would like to take a course similar to that offered last year, please contact Miss Beatrice Yokota at 6-6171 local 24.

## HAWAII DISTRICT

The Nurses' Association, County of Hawaii, were co-sponsors with the Hawaii Chapter of the National Foundation for Infantile Paralysis and the Red Cross Nursing Service of an institute on Poliomyelitis Nursing. The institute was held in Hilo on June 2 and 3.

Mrs. Peggy Wiperman, director of nurses at Hilo Memorial Hospital, has resigned as of June 1, 1952. Until her successor, Mrs. Dorothy Kaladic, arrives from the mainland the first of the year the position will be filled by Mrs. Elizabeth Stillman.

Miss Helen Kitagawa was married to Masanori Hongo on May 17, 1952.

Miss Minnie B. Shelton, employed at Kohala hospital for the past several years, has returned to the mainland. After a brief visit with her family in Kentucky, she will tour Europe for a year.

Mrs. Opal Currie, R.N., of Los Angeles, is relieving Mrs. Lavelle Sakai as director of nurses at the Kohala Hospital while the latter tours the mainland with her husband, Supervisor Sakuichi Sakai. The Sakais plan to return in August.

## KAUAI DISTRICT

The Kauai Chapter of the American Red Cross conducted a course in Home Nursing and Care of the Sick during the month of March. Eight nurses and two high school teachers attended this series of twelve lectures and demonstrations given by Miss Myrna Campbell, Public Health Nurse on Kauai.

The group was fortunate to have Miss Campbell as instructor for she has had much experience in teaching Red Cross Home Nursing classes.

Many adaptations and improvisations were demonstrated to the group and subsequently practiced by members during class sessions. There was little difficulty in obtaining volunteer patients due to the pleasurable appeal of being waited on, the soothing back rubs, and the pleasant sympathetic approach of the nurses. Indeed it was fun to project ahead in years and assume the role of an aged grandmother replete with aching bones and a hearing disability.

## NURSES' ASSOCIATION, DISTRICT OF OAHU

The Nurses' Association, District of Oahu, in conjunction with the School of Practical Nurse Training, presented at the district's regular monthly meeting in the Mabel Smyth Auditorium in June a play entitled "Orphans of the Past."

The play had its initial introduction on Sunday, June 1, at the Mabel Smyth Auditorium, and has been subsequently presented at Puunui Community Association, Palama Settlement, and Moiliili Community Association on June 3, 4 and 5, respectively.

This long one-act play, comprising three scenes, portrayed in an extremely moving and graphic manner the problems of the elderly, chronically ill patient. The action of the play, in developing and dealing with these problems, brought into sharp focus the role and function of the practical nurse.

"Orphans of the Past" was written specifically for the occasion by Aldyth and Ray Morris, authors of several prize winning one-act plays and radio scripts. It was directed by Phyllis T. Shield, a talented young actress who has played in many productions here and on the mainland and is director of the Phyllis Shield Children's Theatre.

The cast was composed of seven veterans of the stage, several of whom have played prominent roles in mainland productions.

The idea of writing, producing, and presenting a play with its focus on the elderly, chronically ill patient really seems nothing short of inspired, since geriatrics and chronic illness are of such timely concern in medicine, nursing, and human relations. And how might they be more effectively depicted than through the artistic medium of the theatre, and in this instance with such professional finesse and exquisite sensitivity? Congratulations are surely in order for all of those who contributed to the tremendous success of the production—the authors, director, cast, production staff, and committee members of the Nurses' Association and the School of Practical Nurse Training. Mahalo nui loa!

\* \* \*

At this same meeting the association had the unique pleasure of welcoming to its membership Mr. Lawrence Katsuyama, Director of Nurses at Kuakini Hospital. Although there are a number of male nurses registered to practice in the territory, Mr. Katsuyama is the first to become a member of the association.

\* \* \*

The district and territory is fortunate to have back again among its active members Miss Laura Draper. She resumed her post in the Health Department as Chief of the Bureau of Public Health Nursing on June 2 following a month's stay in Phoenix, Arizona which had been preceded by an extended vacation in New Zealand.

## BOOK REVIEW

### *Social Aspects of Illness.*

By Carol H. Cooley, 305 pp., Price \$3.25, W. B. Saunders Company, Philadelphia, 1951.

This compact volume of approximately three hundred pages was developed out of the experience of a medical social worker in the teaching of student nurses. The wealth of its content derives not only from her own

experiences in dealing with sick people, but also from her contribution to the education of student nurses in a large urban center.

The content of the chapters is well defined. The author stresses the team relationship of the nurse within the hospital and between the nurse and community resources. The information which is given regarding usual services of agencies is well focused and simply developed. The material also gives assistance to the nurse in knowing what to observe, in interpreting her observations and in the basic process of interviewing. However, she fails to point out the importance of nurse's attitudes and feelings in relation to an individual patient or a particular problem, and to clarify the difference in skill in relation to social problems between the nurse and the social worker.

At the end of each chapter there is a brief summary, a list of questions based on the content of the chapter, and a pertinent bibliography. There are references to statistical studies and other data throughout the book.

The book would seem a very useful one in teaching student nurses and as well public health nursing students, and would likely be a helpful book for younger less experienced social workers.

CLAIRE CANFIELD, R.N.

## NURSING SERVICE BUREAU AND PHYSICIANS' EXCHANGE

The Nursing Service Bureau and Physicians' Exchange was purchased by the Nurses' Association, District of Oahu, from the Nurses' Association, Territory of Hawaii, on March 26, 1952.

The Nurses' Association, Territory of Hawaii, has maintained the Nurses' Registry since 1934. Under the sponsorship of the Nurses' Association, Territory of Hawaii, the Nursing Service Bureau assumed responsibility for placement of nurses on a Territorial level. Since the employment of an Executive Secretary by Nurses' Association, Territory of Hawaii, and the inception of the Counseling and Placement program on a National level, all job placements are handled through the Nurses' Association, Territory of Hawaii Counseling and Placement Service; consequently, the function of the bureau has narrowed to the establishment of a central registry for private duty nursing, which includes both professional and practical nurses.

Mrs. I. Storme, director during the past two years, and her staff deserve great credit for the fine organization and service they have developed.

Mrs. Violet Hyatt Mobbs has been appointed to succeed Mrs. Storme as director.

There is 24 hour coverage at the Nursing Service Bureau and Physicians' Exchange, and the schedule of duty is as follows:

7:00 a.m. - 3:00 p.m.	Mrs. V. Mobbs
3:00 p.m. - 11:00 p.m.	Mrs. Ine Higa
11:00 p.m. - 7:00 a.m.	Mrs. Janet Harris
Relief	Mrs. Marian Lyman



# Index to Volume 11

By Title, Subject and Author

		Page		Page
<b>A</b>				
Abel, Marjorie (See Matsumoto, Eleanor)			Ishii, Albert H.	302
Accidental Poisoning in Children	83		Kawasaki, I. A.	230
Admission X-ray Program in a General Hospital	221		Kobayashi, C. K.	302
Akatsuka, Florence			Kometani, John T.	101
Cerebral Palsy	50		Kuramoto, Kikuo	300
Albert, Sister Mary			Lowrey, John J.	162, 163
Standard Scores and State Board Examinations	242		Marshall, Donald C.	32
Anderson, Elisabeth K.			McCorriston, C. C.	374
Zinc Sulfate Turbidity Test in Hepatobiliary			Mermod, Leon E.	162
Disease	17		Miller, Carey D.	300
Anesthesia and Postoperative Care and			Molyneux, A. V.	163
Oxygen Therapy	46		Moriarty, John L.	301
Antidotes for Destruction	19		Nelson, Tell	32
Arnold, Jr., Harry L.			Perlstein, Robert N.	40
Indispensability of Stress	358		Quisenberry, Walter B.	301
President's Page	294		Richardson, B. Allen	33, 100, 162, 301
Arrhythmias, Treatment with Lanatoside C	88		Rusch, Kenneth H.	231
Asato, Mildred			Schultz, F. Bernard	40
Poliomyelitis Nursing Institute	401		Shupp, M.	101
<b>B</b>			Simon, H. Joseph	32
Barnard, Robert D.			Sorg, Paula	245
Hodgkin's Disease (Correspondence)	169		Spencer, Frank C.	161
Bell, Douglas H.			Stansell, Gilbert B.	40
Sclerosing Lipogranuloma	291		Stevens, M. E.	373
Berk, M. E.			Strode, J. E.	161, 373
New Drugs	110		Tilden, I. L.	230
Bickerton, Agnes C. (See Miller, Carey D.)			Toreson, Ruth	162
Bigalow, Leah			Van Derhyden, Dorothy B.	316
Preoperative and Postoperative Nursing Care	47		Walker, Dean M.	231
Book Reviews			Walker, H. H.	301
Allison, Samuel	373		Walsh, Wm. M.	100
Arnold, H. L.	161		Washko, Peter J.	231
Arnold, H. L., Jr.	33, 101, 163, 374		Wong, Robert T.	231
Arthur Philip S.	162		Wong, Wayne W.	231, 374
Berk, Morton E.	100, 374		Wurl, Otto	374
Brechner, Verne	373		Yamauchi, Shoyei	33
Brown, R. O.	162		Yee, Samuel L.	301
Canfield, Claire	403		Bowles, H. E.	
Chang, H. C.	373		Conduct of Premature Labor	286
Chappell, Raid	374		Boyd, William	
Civin, W. Harold	40, 100, 162, 302		Pathology of the Ground Substance of the	
Cochran, Joy E.	302		Mesenchyme	353
Cooksey, Virginia	230		Bradfield, Vergil F.	
deHay, Raymond M.	100		Territorial Hospital Plan	173
Doolittle, S. E.	33, 300		Broader Horizons in Maternity Nursing Services	397
Enright, James R.	230		Burns, Marion C. (See Middleton, Elizabeth H.)	
Felix, John M.	41		<b>C</b>	
Freeman, G. C.	161		Cerebral Palsy	50
Gilbert, Fred I.	40, 101		Challenge of Chronic Illness	311
Gotshalk, Henry C.	32, 33, 231		Childbirth and Infant Care Among Hawaiians	107
Haff, A. O.	41		Chun, L. T.	
Hansen, Eleanor H.	101		Accidental Poisoning in Children	83
Hartwell, Alfred S.	300, 301		Civin, W. Harold (See Anderson, Elisabeth K.)	
Hata, Tadao	161		(See Bell, Douglas H.)	
Hodel, George Hill	32		Cloward, Ralph B.	
Hill, Rogers Lee	373		Surgical Treatment for Ruptured Lumbar	
			Intervertebral Discs	279

	Page
Conduct of Premature Labor.....	286
Conjunctivitis Epidemic in Hawaii.....	94
Correspondence	
Catastrophic Health Insurance.....	239
Hodgkin's Disease .....	169
No "Trend" at Kapiolani Hospital? .....	379
Council (See Reports)	

**D**

Dental Caries Among School Children in Hawaii....	22
Dental Caries in Students of Japanese Ancestry....	216
Dental Survey of Inductees in Hawaii.....	214
Domzalski, C. A., Jr.	
Medical News.....	29, 97, 159, 228
This Is What's New! .....	297, 369

**E**

Editorials	
AMA Dues .....	226
AMA House of Delegates.....	367
AMA Resignations .....	155
Associate Members Take Notice.....	296
Catastrophic Health Insurance.....	156, 226
Community Calendar of Events.....	227
Corticotropin and Cortisone.....	95
Epidemic Hemorrhagic Fever.....	295
Federal Medical Services.....	27
Fifth Pan-Pacific Surgical Congress.....	25, 95
Give Through the AMA Education Foundation!..	368
Group Insurance While in Armed Forces.....	156
Hawaii NSCAA Services to Physicians.....	28
How Good Is Isonicotinic Acid Hydrazide? .....	296
Kapiolani Hospital Reverses a "Trend".....	227
Leahi Hospital, 1901-1951.....	25
Lower Mortality, Lower Morality? .....	96
Menace of Epidemic Diarrhea.....	26
Much Obligated, Marjorie Shearon.....	367
New Cytologic Technic for Gastric Cancer.....	225
New Medical Care Program.....	26
Rehabilitation: A Growing Problem.....	26
St. Francis Hospital's Quarter-Century.....	367
State Journal Editors' Conference.....	155
Texas Institution for Spastics.....	227
Thanks to Cancer Society and Tuberculosis Association .....	296
Edwards, Walton M.	
Potassium Bromate Poisoning.....	362

**F**

Fanning, Robert J.	
Dental Caries Among School Children in Hawaii .....	22
Dental Survey of Inductees in Hawaii.....	214
Ferkany, Joseph E.	
Obstructive Pneumonitis of the Middle Lobe.....	149
Fox, Kathryn	
Urological Nursing .....	49

**G**

Group Teaching of Diabetic Patients.....	241
--	-----

**H**

Halford, F. J.	
Antidotes for Destruction.....	19
Hartwell, A. S. (See Reports, Delegates)	
Hawaii Medical Service Association	
Administration of the Plan.....	376
Functions of the Committees.....	307
Its Place in the Community.....	232
Your Answer .....	164
Holmes, Wm. John	
Conjunctivitis Epidemic in Hawaii.....	94

**I**

Index to Advertisers.....	62, 126, 190, 258, 330, 418
Indispensability of Stress.....	358
Inter-Island Nurses' Bulletin.....	45, 107, 171, 241, 311, 397
Involuntional Melancholia .....	152
Izumi, Homer F. (See Reports, Delegates)	

**J**

Johnsen, C. E., Jr.	
Anesthesia and Postoperative Care.....	46
Preoperative Care and Anesthesia.....	45
Jones, Virginia	
University of Hawaii School of Nursing.....	315

**L**

Leedham, Charles L. (See Edwards, Walton M.)	
Epidemic Hemorrhagic Fever (Editorial).....	296
Rheumatic Heart Disease in Inductees in Hawaii.....	211
Library Reports.....	30, 98, 160, 229, 298, 372
Lowrey, John J.	
Subdural Hematoma in Infants.....	145

**M**

MacBride, Alison	
Childbirth and Infant Care among Hawaiians.....	107
Preparing Nurses to Teach Classes for Prospective Parents .....	400
Maeda, T. H.	
Parenteral Fluid Administration.....	110
Matsumoto, Eleanor	
Group Teaching of Diabetic Patients.....	241
McArthur, R. J.	
President's Page .....	366
McComas, Mrs. Mapuana	
Hawaii NSCCA Services to Physicians.....	28
Medical News (See: This Is What's New!)	
Middleton, Elizabeth H.	
Admission X-ray Program in a General Hospital..	221
Miller, Carey D.	
Dental Caries in Students of Japanese Ancestry....	216
Murray, Douglas H.	
Treatment of Viral Enteritis with Vitamin B Complex .....	289

**N**

New Drugs .....	110
Notes and News.....	37, 104, 166, 237, 308, 380



**O**

	Page
Obituary	
Morgan, James Albert.....	96
Obstructive Pneumonitis of the Middle Lobe.....	149
Officers, Listed.....	15, 81, 143, 209, 277, 336

**P**

Page, Robert Collier	
Federal Medical Services (Editorial).....	27
Parenteral Fluid Administration.....	110
Parke, Gerald L. (See Miller, Carey D.)	
Paskowitz, Dorian	
Challenge of Chronic Illness.....	311
Pathology of the Ground Substance of the	
Mesenchyme .....	353
Poliomyelitis Nursing Institute.....	401
Potassium Bromate Poisoning Incident to Ingestion	
of "Cold Wave" Neutralizer.....	362
Preoperative and Postoperative Nursing Care.....	47
Preoperative Care and Anesthesia.....	45
Preparing Nurses to Teach Classes for	
Prospective Parents .....	400
President's Address, N.A.T.H., 1951.....	171
President's Message, Nurses.....	397
President's Page .....	294, 366

**Q**

Quisenberry, W. B. (See Tilden, I. L.)

**R**

Refresher Course, Summer 1951.....	110
Reports	
County Societies	
Hawaii .....	34, 102, 165, 235, 304, 377
Honolulu .....	35, 102, 165, 235, 305
Kauai .....	36, 103, 165, 236, 304, 377
Maui .....	36, 103, 165, 236, 303, 379
Territorial Medical Association	
AMA Clinical Session.....	157
AMA Public Relations Conference.....	158
Annual Meeting .....	382
Council .....	34, 233
Delegates' Report .....	370
Rheumatic Heart Disease in Inductees in Hawaii.....	211
Rubbelke, Leona	
Broader Horizons in Maternity Nursing Services..	397
Rusch, Kenneth H.	
Involutional Melancholia .....	152

**S**

Schlosser, Adele P. (See Middleton, Elizabeth H.)	
Schultz, F. Bernard	
Treatment of Arrhythmias with Lanatoside C.....	88
Sclerosing Lipogranuloma .....	291
Smith, Larry A. (See Leedham, Charles L.)	
Spencer, F. C. (See Tilden, I. L.)	
Standard Scores and State Board Examinations.....	242
Stewart, Steele F.	
Catastrophic Health Insurance (Correspondence)..	239
Subdural Hematoma in Infants.....	145
Surgical Treatment for Ruptured Lumbar	
Intervertebral Discs .....	279

**T**

Territorial Hospital Plan.....	173
This Is What's New! .....	29, 97, 159, 228, 297, 369
Thompson, Arlene	
President's Address .....	171
President's Message .....	397
Tilden, I. L.	
New Cytologic Technic for Gastric Cancer	
(Editorial) .....	225
Treatment of Viral Enteritis with Vitamin B	
Complex .....	289
Tucker, Russell	
No "Trend" at Kapiolani Hospital?	
(Correspondence) .....	379

**U**

Umi Makahiki I Hala.....	39, 105, 168, 239, 299, 378
University of Hawaii School of Nursing.....	315
Urological Nursing .....	49

**V**

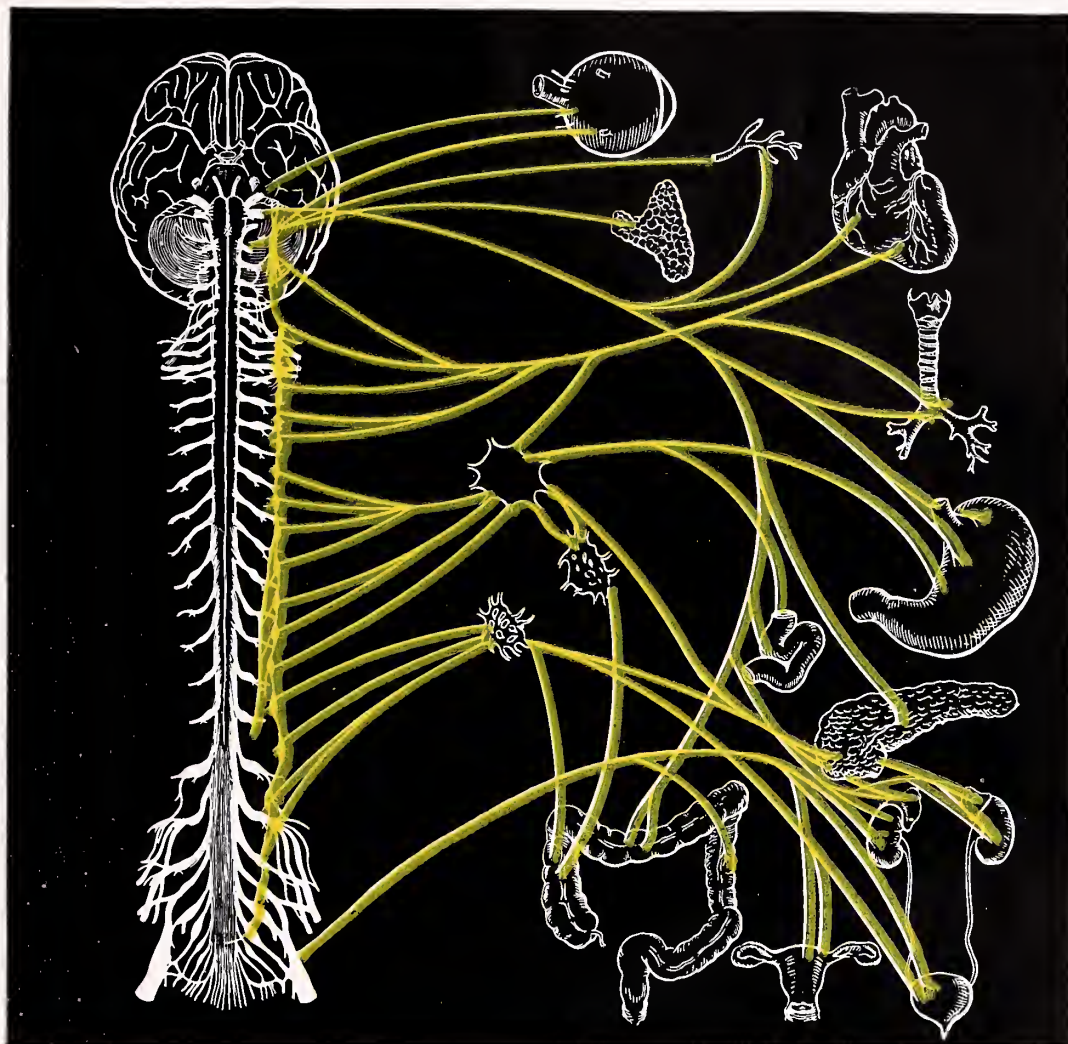
Veltmann, J. R.	
HMSA—Administration of the Plan.....	376
HMSA—Functions of the Committees.....	307
HMSA—Its Place in the Community.....	232
HMSA—Your Answer .....	164

**W**

White, J. Warren	
Texas Institution for Spastics (Editorial).....	227
Wilbar, C. L., Jr.	
No "Trend" at Kapiolani Hospital?	
(Correspondence) .....	379

**Z**

Zinc Sulfate Turbidity Test in Hepatobiliary	
Disease .....	17



**Excess neural stimulation** over the parasympathetic subdivision plays an important role in such clinical conditions as peptic ulcer, certain forms of gastritis, pylorospasm, pancreatitis, spastic colon, bladder spasm and hyperhidrosis.

**Banthine<sup>®</sup>** Bromide (brand of methantheline bromide) is a true anticholinergic which inhibits parasympathetic stimuli, acting selectively on the gastrointestinal and genitourinary systems. It exerts little or no influence on the normal cardiovascular system. Banthine is supplied in oral and parenteral dosage forms.





**S**uperior,  
**U**ntiring, and  
**M**ultiple checking systems  
**M**eriting  
**E**xactitude, in all phases  
**R**elative to  
**S**uperior Prescription Practice



CLINTON D. SUMMERS  
PRESCRIPTION • PHARMACISTS

PHONES 66-0-44  
68-8-65

THIRD FLOOR-YOUNG BUILDING  
HONOLULU, HAWAII

## WYDASE IN OFFICE PRACTICE

Part of a series on its everyday use



### Reduction of Simple Fractures

In the reduction of simple fractures, Wydase added to a local anesthetic solution\*:

1. Hastens onset of anesthesia
2. Promotes wide diffusion of injected anesthetic
3. Reduces swelling, thus permitting snug-fitting cast

Supplied: Vials of 150 and 1500 turbidity-reducing (TR) units.

*\*150 TR units when added to 25 cc. of anesthetic usually suffices. See package circular.*



Lyophilized

# W Y D A S E<sup>®</sup>

Hyaluronidase Wyeth

*Wyeth* Incorporated • Philadelphia 2, Pa.



**pontocaine**  
*hydrochloride*  
*hyperbaric (dextrose)*  
*solution*  
**for**  
**spinal anesthesia**  
**... saddle block**



Pontocaine, trademark reg. U. S. & Canada, brand of tetracaine

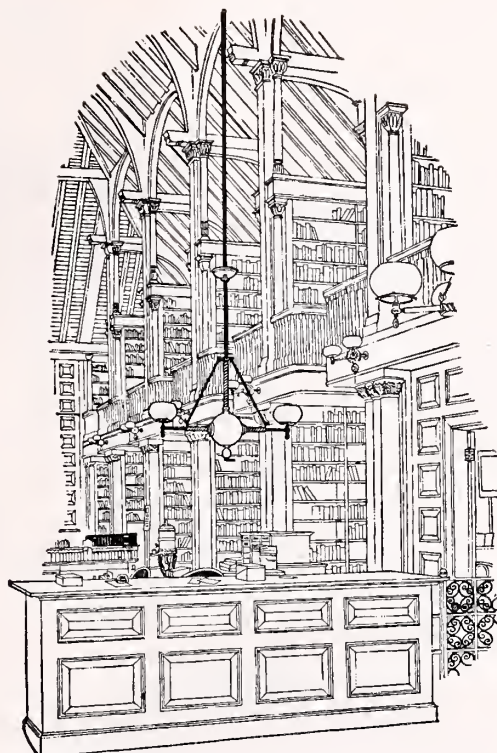
**HOW SUPPLIED:**

**For saddle block, 0.2% Hyperbaric Solution in 6% dextrose, ampuls of 2 cc. (4 mg.), boxes of 10.**

**For spinal anesthesia, 0.3% Hyperbaric Solution in 6% dextrose, ampuls of 5 cc. (15 mg.), boxes of 10.**

*Winthrop-Stearns* INC.,  
NEW YORK, N. Y. WINDSOR, ONT.

*New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.*



Interior of the  
Howard Memorial Library,  
New Orleans, La.

*From among all antibiotics Otolaryngologists often choose*

# AUREOMYCIN

*because*

*Hydrochloride Crystalline*

Aureomycin appears rapidly in the tissues of the ear, nose and accessory sinuses, and in the cerebrospinal fluid.

Aureomycin, when given intravenously, attains maximum concentrations in the plasma within 5 minutes.

Aureomycin exhibits little tendency to favor the development of bacterial resistance.

Aureomycin has been reported to be effective against susceptible organisms in the following conditions frequently seen by otolaryngologists:

Laryngeal Infections • Otitis Externa • Otitis Media  
Mastoiditis • Pharyngitis • Sinusitis • Tonsillitis

*Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.*

*Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100.*

*Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.*

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* 30 Rockefeller Plaza, New York 20, N. Y.





*In the City of Bagdad* lived Hakeem, the Wise One,  
and many people went to him for counsel, which he gave freely to all, asking nothing in return.

There came to him a young man, who had spent much but got little, and said: "Tell  
me, Wise One, what shall I do to receive the most for that which I spend?"

Hakeem answered: "A thing that is bought or sold has no value unless it contains that which  
cannot be bought or sold. Look for the Priceless Ingredient."

"But what is this Priceless Ingredient?" asked the young man.

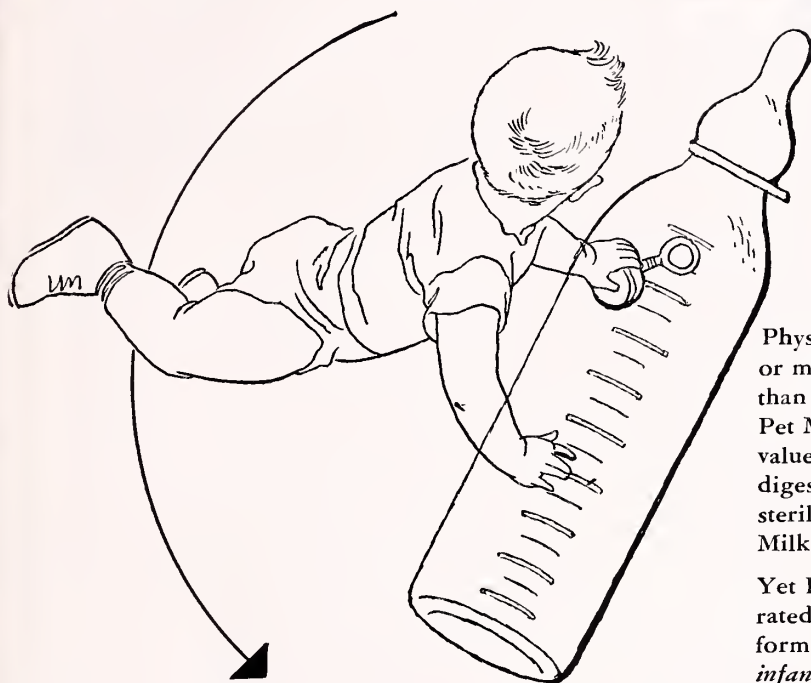
Spoke then the Wise One: "My son, the Priceless Ingredient of every product in the market-  
place is the Honor and Integrity of him who makes it. Consider his name before you buy."

*Copyright E. R. Squibb & Sons*

**E·R·SQUIBB & SONS**

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

**Pet Milk**  
**keeps**  
**babies**  
**growing** **up**



**... infant**  
**feeding**  
**costs**  
**down**

**FAVORED FORM OF MILK FOR INFANT FORMULA**

Physicians know there is no better or more nutritious milk for babies than Pet Evaporated Milk. Because Pet Milk is complete in the food values of milk . . . comparable in digestibility to human milk, and sterilized in its sealed container, Pet Milk is always a *safe* milk for babies.

Yet Pet Milk, the original evaporated milk, costs less than any other form of milk—*far less than special infant feeding preparations!* That's especially important in these days of high living costs . . . because it means that young parents, using Pet Milk, can save from \$10 to \$50 in the first year on baby's food bill alone.

Recommend inexpensive Pet Milk for the babies in your care. See how this good milk assures all needed nourishment and saves precious dollars, too.





<b>T-BONE STEAKS</b> .....	<b>lb. 31¢</b>
<b>SLICED BACON</b> .....	<b>lb. 29¢</b>
<b>PORK LOINS</b> .....	<b>lb. 24¢</b>
<b>RIB ROAST</b> .....	<b>lb. 28¢</b>

Prices advertised in July 1941 newspapers.

★ ★ ★

## IS YOUR Insurance STILL BASED ON 1941 PRICES?

Have you figured out — lately — if your Life Insurance could really take over for you?

Doesn't the security you planned for your family, say 11 years ago, look pretty thin in the face of 1952 prices?

It may be easier than you think to bring your Life Insurance into line with today's living costs. Let a trained New England Mutual career underwriter show you how.

★ ★ ★

## NEW ENGLAND MUTUAL LIFE

Insurance Company of Boston

100th Year of Service in Hawaii

GENERAL AGENT

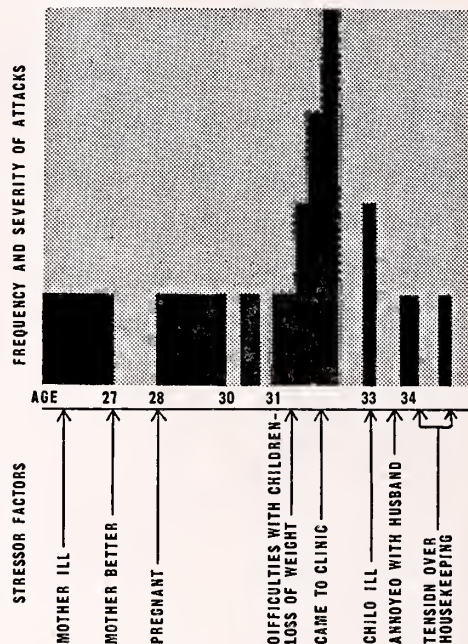


## HOME INSURANCE CO. OF HAWAII LTD.

Honolulu . . . King St. between Fort & Bishop  
Maui—Lufkin Ins. Agency . . . . . Wailuku  
Kauai—J. M. Lydgate, Ltd. . . . . Lihue  
Hawaii . . . . . First Trust Co. of Hilo, Ltd.

## Stress . . .

Stressor factors which evoke autonomic response occur often in our civilization. They are not always of external origin; frequently, stress springs from the "well of uncertainties, the fears, the angers, and the hostilities that an inadequate childhood nurtures in troubled people in a troubled world."<sup>1</sup>



After: Relationship Between Life Stress And Symptoms — Stevenson, I.: G.P. 4: 67 (Dec.) 1951

When emotions aroused by these stresses are not dissipated in appropriate biological behavior, heightened autonomic impulses beat against a "moored" physique.<sup>1</sup>

Incessant "emotional buffeting" impinging on labile autonomic pathways is likely to produce deviations from normal body function and a *rash of symptoms*. In such cases, both branches of the autonomic nervous system are involved. For symptomatic relief oral administration of cholinergic and adrenergic blocking agents and central sedation has proven successful. Drugs effective for the several actions respectively are: belladonna alkaloids, ergotamine tartrate and phenobarbital. These drugs may be used individually or in combination,\* as required by the individual case, to effect more stable function of the autonomic nervous system, thereby "dampening" overactivity of the involved organ systems.

\* Dosage of each ingredient adjusted to the needs of the particular patient.

<sup>1</sup>Cleghorn, R. A. and Grabam, B. F.: *Recent Progress in Hormone Research*, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.

**Sandoz Pharmaceuticals**

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, N. Y.



**WELCH  
ALLYN**

Diagnostic Set  
No. 983

The league-leading hitter wouldn't maintain his batting average long using a tennis racket . . . or even an inferior bat.

Just so the doctor's skill needs and deserves the help of the finest instruments for accurate diagnosis without waste of time.

That is why more doctors have chosen the efficient Welch Allyn No. 110 Ophthalmoscope and the easy-to-use No. 216 Operating Oscope than any other instruments of their kind ever made.

They are shown here in Welch Allyn's Sandura Case, which is far more durable and more compact than old-style cases, and designed to be sterilized inside and out.

**HOTEL IMPORT COMPANY**

**DIVISION OF THE VON HAMM-YOUNG COMPANY**

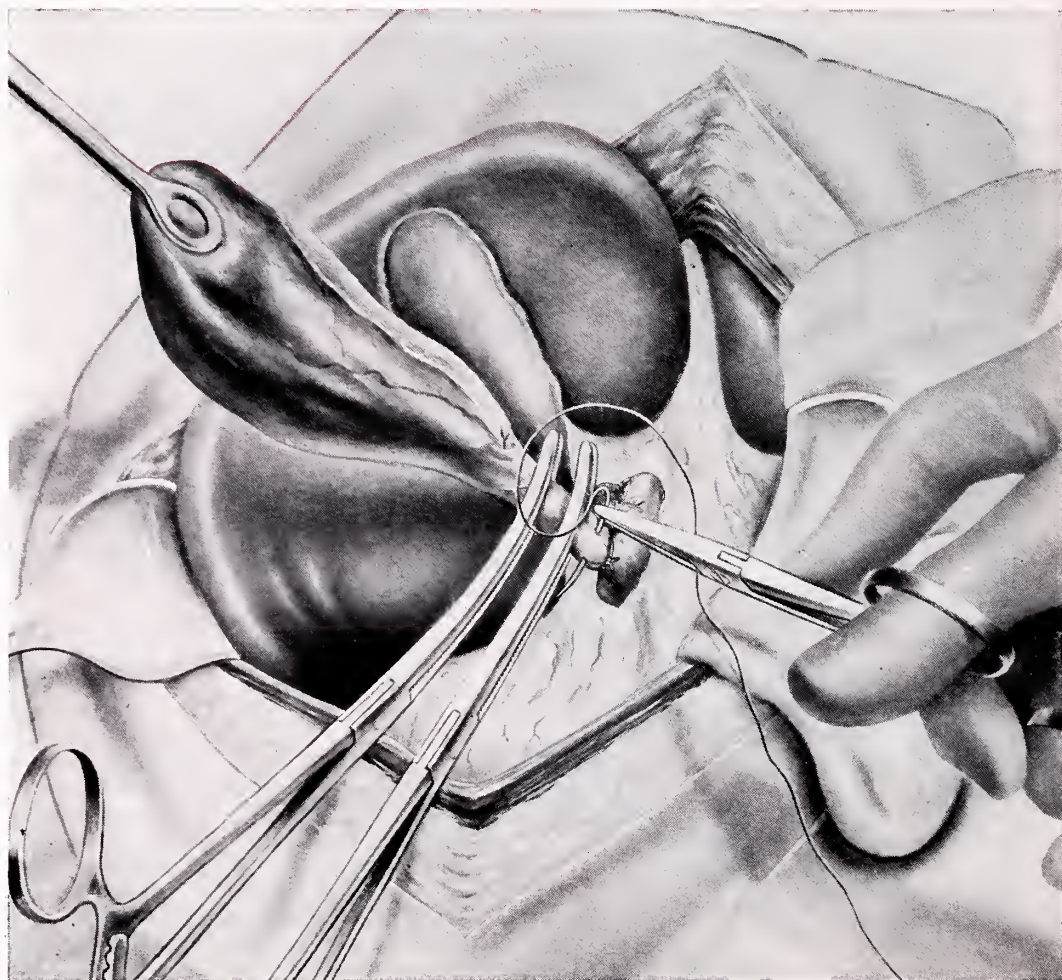
718 Kawaiahao St.

Phone 6-3562

Honolulu, T. H.



*for this critical ligation* **"timed-absorption"**



The success of a cholecystectomy depends on factors in the patient, in the surgical technic and in the suture material used. In a critical step, such as ligating the cystic duct, the skill of the surgeon must be supported by a dependable ligature, which will not digest prematurely.

**"Timed-absorption" surgical gut assures a predictable digestion rate that can be measured.**

By an exclusive improved process, D & G "timed-absorption" surgical gut is accurately tanned in *graded degrees* from the outer surface inward to achieve a more logical absorption curve. Maximum resistance to digestion is assured during *the critical first 4 days* when there is least fibrosis. As fibrosis develops and the need for artificial support lessens, the rate of absorption increases. The ligature on the cystic duct lasts until fibrosis is completed and finally absorbed.

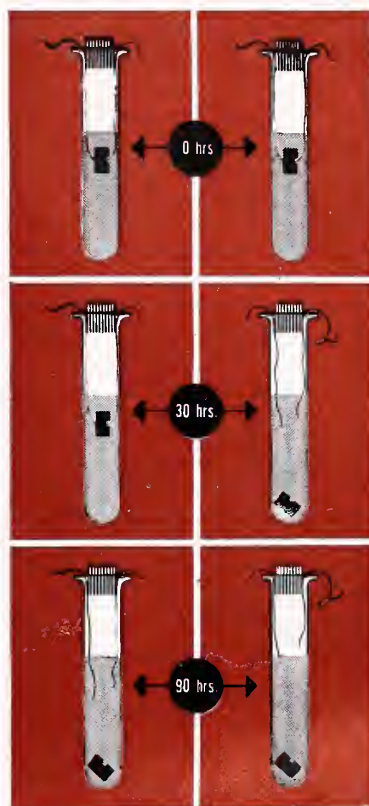
## *surgical gut sutures will not digest prematurely*

### 90 hours vs. 30 hours

Comparison of D & G "timed-absorption" medium chromic surgical gut suture, size O, with non timed-absorption medium chromic surgical gut suture, size O. Weights are suspended from each in trypsin solution. Note that at the end of 30 hours "timed-absorption" surgical gut remains intact; the weight is still held suspended up to 90 hours. Contrast with non timed-absorption chromic surgical gut suture which has begun to digest and breaks under the weight at 30 hours. In human tissue all chromic sutures are digested *more slowly*, but the ratio between the two types remains the same.

*D & G surgical gut sutures have a special matte finish. They tie readily and do not slip at the knot. Pliability is exceptional and tensile strength, diameter for diameter, is guaranteed to be unexcelled by any other brand.*

*There is a D & G suture for every surgical purpose, available through responsible surgical supply dealers everywhere.*



Davis & Geck  
"timed-absorption"  
sutures

non timed-absorption  
chromic sutures

## "timed-absorption" sutures

### *Davis & Geck, Inc.*

A UNIT OF *AMERICAN Cyanamid COMPANY*

57 Walloughby Street,



Brooklyn 1, N. Y.

*Surgeons agree on D & G*





Anyone for shuffleboard?  
... or do you like to watch  
the miniature ponies run?



Care for a card game ...  
bridge, canasta, cribbage?  
Game Room always open



The outdoor pool for an  
afternoon plunge... come  
on in, the water's fine



How about a movie after  
dinner, or a musicale?  
Just walk in ... it's free

# LURLINE

Here's the sauce on your  
sundae, the gravy on your  
potatoes ... the little things  
that add up to a wonderful  
Lurline trip ... to the biggest  
bargain in mainland travel

... all this, plus  
famously fine food  
luxurious stateroom  
your transportation  
is included in your fare

as little as \$260 round trip (plus tax)

**Matson Lines** 1021 Bishop Street  
2347 Kalakaua Avenue  
Phone 50945

OR SEE ANY AUTHORIZED TRAVEL AGENT



Dancing on the Veranda,  
a night club at sea ...  
with no cover charge



Afternoon tea on deck  
a chance to stretch out,  
take a relaxing snooze



Like icebox raiding?  
the chef has a midnight  
snack all ready for you



Like living island style?  
Pitch in when a picnic  
lunch is served on deck

## INDEX TO ADVERTISERS

	PAGE		PAGE
Abbott Laboratories .....	340	Matson Lines .....	418
Ames Company, Inc. ....	348	Mead Johnson & Co. ....	420
Ayerst, McKenna & Harrison .....	351	Merck & Co., Inc. ....	341
Borden Company .....	352	Parke, Davis & Company .....	334, 335
Carnation Company .....	343	Pet Milk Company .....	413
Dairymen's Association, Ltd. ....	375	Chas. Pfizer & Co., Inc. ....	344, 345
Theo. H. Davies & Co., Ltd. ....	396	Philip Morris & Co., Ltd., Inc. ....	346
Davis & Geck, Inc. ....	416, 417	Sandoz Pharmaceuticals .....	414
Don Baxter, Inc. ....	349	Schering Corporation .....	337
Eaton Laboratories, Inc. ....	339	G. D. Searle & Co. ....	407
Eli Lilly and Company .....	333, Insert	Sharp & Dohme .....	342
Ethicon Suture Laboratories, Inc. ....	Insert	E. R. Squibb & Sons .....	412
Hawaiian Electric Company .....	347	Clinton D. Summers .....	408
Hawaiian Surgical Supply Company .....	350	Upjohn Company .....	419
Home Insurance Company .....	414	Wander Company .....	338
Hotel Import Company .....	415	Winthrop-Stearns, Inc. ....	410
Lederle Laboratories .....	411	Wyeth Incorporated .....	409



# steroids for strength

Patients undergoing the stress of burns, surgery, severe infections, medical or surgical convalescence often need reserves of strength to meet the increased demand of adrenal cortical output.

To give strengthening steroids by intravenous, intramuscular or subcutaneous injection...

## Upjohn Adrenal Cortex Extract

Upjohn research study of the adrenal cortex and its hormones has contributed and seeks to contribute further to the use of cortical steroids in medical practice.

Each cc. of Upjohn Adrenal Cortex Extract contains the biological activity equivalent to 0.1 mg. of 17-hydroxycorticosterone, as standardized by the Rat Liver Glycogen Deposition test... Alcohol 10%.

Supplied in 10 cc. and 50 cc. vials.

*a product of*

**Upjohn**

**Research**

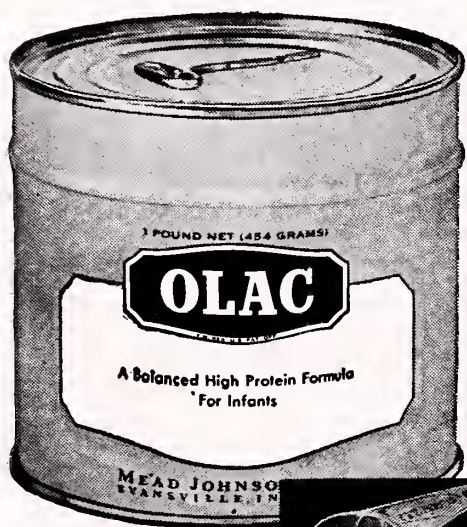
*for medicine... produced with care... designed for health*

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN





## A strong start for a healthy childhood



This convenient measure  
is enclosed in  
each can of Olac



**Olac is Mead's powdered formula designed for optimum nutrition of both full term and premature infants.** Steadily accumulating clinical observations show that babies fed Olac® tend to be sturdy and not pudgy; gain weight without becoming fat; show excellent tissue turgor and muscle development; resist infections well; have good vigor and generally happy dispositions. They get a *strong start*.

**Olac supplies milk protein** in exceptionally generous amounts. Its fat is a highly refined vegetable oil. And Dextri-Maltose® supplements the lactose of the milk.

**In convenient powdered form,** Olac is valuable not only as a regular formula for bottle-fed infants, but as a supplementary or complementary feeding for breast-fed infants.

**Olac is easily prepared** merely by mixing with water. A special measure is enclosed in each can. One packed level measure of Olac to 2 ounces water gives a formula supplying 20 calories per fluid ounce.



**MEAD JOHNSON & CO.**  
EVANSVILLE 21, IND., U.S.A.

















